

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

127229

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>3 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>517 Albany Avenue Oakhaven Convalescent Home</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4 7X-2</u> d. STREET ADDRESS <u>3806 Albemarle St. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Edna Reed Aitcheson</u>		<b>4. DATE OF DEATH</b> Month <u>Nov.</u> Day <u>5</u> Year <u>1961</u>		<b>5. SEX</b> <u>F</u> <b>6. COLOR OR RACE</b> <u>W</u>			
<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Dec. 5, 1894</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>9. AGE</b> (In years last birthday) <u>66</u> IF UNDER 1 YEAR: Months <u>66</u> Days <u>66</u> Hours <u>66</u> Min. <u>66</u>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Stenographer - clerk</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>U.S. Govt</u>			
<b>11. BIRTHPLACE</b> (County, State, or foreign country) <u>Virginia</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>		<b>13. FATHER'S NAME</b> <u>Edwin Reed</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Bertha Shertz</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>579-18-8421</u>			
<b>17. INFORMANT</b> <u>Caroline Aitcheson, 3806 Albemarle St N.W. Wash. D.C.</u> Address <u>3806 Albemarle St N.W. Wash. D.C.</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Embolism</u> DUE TO <u>Hypertensive heart disease</u> Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerosis</u> (c) <u>Arteriosclerosis</u> (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>30 yrs</u> <u>few days?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>0</u>							
<b>20c. TIME OF INJURY</b> Hour <u>19</u> a.m. <u>19</u> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>1956</u>			
<b>20f. (City or town)</b> <u>1956</u>		<b>20g. (County)</b> <u>1956</u>		<b>20h. (State)</b> <u>1956</u>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>11/5/61</u> <b>to</b> <u>11/5/61</u> <b>that (I) (we) last saw the deceased alive on</b> <u>11/5/61</u> <b>and that death occurred at</b> <u>3:58 P.M.</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Chas. H. Wolohan, M.D.</u>		<b>22b. ADDRESS</b> <u>7600 Carroll Ave Takoma Park, Md.</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Chas. H. Wolohan</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>11/8/1961</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Bethel Cemetery</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>The S.H. Hines Company-2901 14th St., N.W.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>NOV 8 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

The R. R. Lines Company - 2501 N. 3rd St.  
Washington, D. C.

AMERICAN AIRWAYS

Chas. H. Newman, Jr.

11/10/1917

1917

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12743

12730

<b>1. PLACE OF DEATH</b> a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING, MD.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WHEATON</b>				c. LENGTH OF STAY IN <b>4 DAYS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WHEATON NURSING HOME</b>				d. STREET ADDRESS <b>9404 BRUCE DR.</b>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>MARTHA OLIVIA ALMQUIST</b>				<b>4. DATE OF DEATH</b> Month <b>11/</b> Day <b>28</b> Year <b>1961</b>			
<b>5. SEX</b> <b>FEMALE</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>9/10/82</b>		<b>9. AGE</b> (In years last birthday) <b>79 yrs.</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own Home</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>SWEDEN</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>	
<b>13. FATHER'S NAME</b> <b>FRANK NOREN</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>WHILHELMINA PETERSON</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES OR U.S. AIR FORCE SECURITY NO.</b> (Yes, no, or unknown) <b>No</b>				<b>17. INFORMANT</b> Address <b>5413 31st Street N.W.</b> <b>Mr. John R. Almquist Washington D.C.</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per item (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: (a) <b>Acute cardiac decompensation</b> (b) <b>Generalized arteriosclerosis</b> (c) <b>(Malnutrition)</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>8 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e):							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>September, 1961, to November 28, 1961,</b> that (I) (we) last saw the deceased alive on <b>November 28, 1961,</b> and that death occurred at <b>5:30 P.M.</b> from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <b>Bennet A. Porter, Jr.</b> M.D.				<b>22b. DATE SIGNED</b> <b>November 28, 1961</b>		<b>22c. PHYSICIAN'S NAME (Type)</b> <b>BENNET A. PORTER JR.</b>	
<b>22d. ADDRESS</b> <b>9301 Colesville Rd, Silver Spring, Md.</b>				<b>22e. REC'D BY REGISTRAR</b>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>		<b>23b. DATE THEREOF</b> <b>12/1/61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>FORT LINCOLN CEMETERY</b>		<b>23d. LOCATION (City, town or county) (State)</b> <b>PRINCE GEORGE'S COUNTY, MARYLAND</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>WARNER E. PIMPHREY, INC.</b>				<b>25. REGISTRAR'S SIGNATURE</b> <b>NOV 30 '61</b>			

TO FUNERAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN 1b <u>40 min.</u>		d. STREET ADDRESS <u>3248 - Ballantyne St. NW</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) <u>Ruth</u>		4. DATE OF DEATH <u>11 127 1961</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/8/93</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ret. teacher (D.C. School Teacher)</u>		9. AGE (In years last birthday) <u>68</u> yrs.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>HERMAN L. AMISS</u>	
14. MOTHER'S MAIDEN NAME <u>Bettie DeVol</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO.		17. IN OR OUT OF STATE <u>above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemiplegia, right, acute, severe</u> DUE TO (b) <u>Cerebral hemorrhage, massive</u> DUE TO (c) <u>Cerebral arteriosclerosis, mod. severe</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u> <u>8 hours</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1954</u> to <u>Nov 27</u> , 1961, that (I) <u>( )</u> last saw the deceased alive on <u>Nov 27</u> , 1961, and that death occurred at <u>9:45</u> PM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Stewart Clapp</u>		22b. DATE SIGNED <u>11.28.61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stewart C. Clapp</u>		22d. ADDRESS <u>4740 Chevy Chase Dr. Chevy Chase Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>11/30/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>St. Hines Co</u>		24. ADDRESS <u>2901 14th NW</u>	
25a. REC'D BY REGISTRAR <u>Nov 29 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

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Westborough

St. Joseph

St. Paul

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St. Peter

St. James

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St. Joseph  
St. Paul  
St. John  
St. Peter  
St. James

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12745						12732					
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>9 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Georgia</b> b. COUNTY <b>Lowndes</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Valdosta</b> d. STREET ADDRESS <b>1709 Charlton Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>WILEY ROBERT ARNOLD</b>						4. DATE OF DEATH Month <b>November</b> Day <b>28</b> Year <b>19 61</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 12, 1927</b>		9. AGE (In years last birthday) <b>34</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Credit Manager</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Georgia</b>				11. BIRTHPLACE (County & State, or foreign country) <b>USA</b>			
13. FATHER'S NAME <b>Donald R. Arnold</b>						14. MOTHER'S MAIDEN NAME <b>Lillie M. Stalvey</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>						16. SOCIAL SECURITY NO. <b>256-26-9240</b>					
17. INFORMANT <b>The Medical Record</b>						18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aortic insufficiency</b> DUE TO (b) <b>Rheumatoid spondylitis &amp; aortitis</b> DUE TO (c) <b>16 years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <b>November 19, 1961</b> to <b>Nov. 28, 1961</b> that (I) (we) last saw the deceased alive on <b>Nov. 28, 1961</b> , and that death occurred at <b>2:20 PM</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Paul A. Ebert, M.D.</b>						22b. DATE SIGNED <b>11/29/61</b>					
22c. PHYSICIAN'S NAME (Type) <b>Paul A. Ebert</b>						22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)					
<b>Burial-transit 11-29-61</b>		<b>Sunset Hill Cemetery</b>		<b>Valdosta, Georgia</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>						25a. REC'D BY REGISTRAR <b>Bethesda, Md.</b>					
						25b. REGISTRAR'S SIGNATURE <b>Arthur S. Krand</b>					



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Robert A. Fennell, The Clinical Center, Bethesda, Md.

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Robert A. Fennell

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Nov. 19, 41

The Clinical Center, National Institute of Health, Bethesda, Md.

Robert A. Fennell, The Clinical Center, Bethesda, Md.

Robert A. Fennell, Bethesda, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park,</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium &amp; Hospital</b>		d. STREET ADDRESS <b>8600-2nd Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Hattie C. Babbitt</b>		4. DATE OF DEATH <b>Nov. 8, 1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 6, 1892</b>
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired- Auditor U.S. Gov't.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>G.A.O.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William E. Brooks</b>		14. MOTHER'S MAIDEN NAME <b>Amanda--</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>?</b>	
17. INFORMANT <b>Edward F. Babbitt</b>		Address <b>Silver Spring, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral infarction</b> DUE TO <b>Cerebral and generalized arteriosclerosis</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension &amp; arteriosclerosis - heart disease - atherosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>2 weeks</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12-20-1959</b> to <b>11-8-61</b> that (I) <b>(no)</b> last saw the deceased alive on <b>11-7-61</b> , and that death occurred at <b>12-1-61</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Jason Geiger</b>		22b. DATE SIGNED <b>11-8-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Jason Geiger</b>		22d. ADDRESS <b>1110 Spring Street, Silver Spring, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/10/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Prince Georges County, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>		25a. REC'D BY REGISTRAR <b>NOV 9 '61</b>	
ADDRESS <b>2901 14th St. N.W. Wash. D.C.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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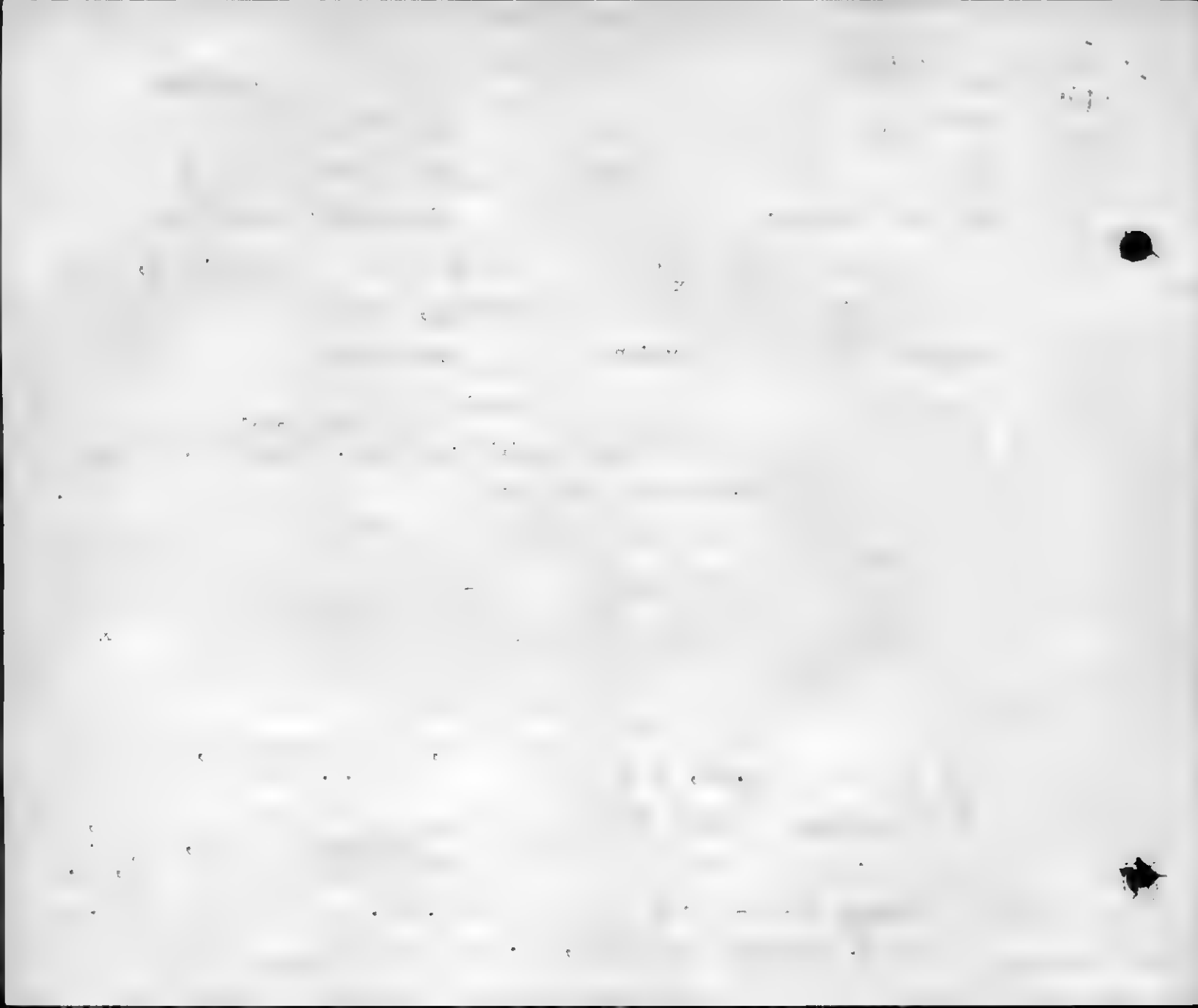
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 and be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

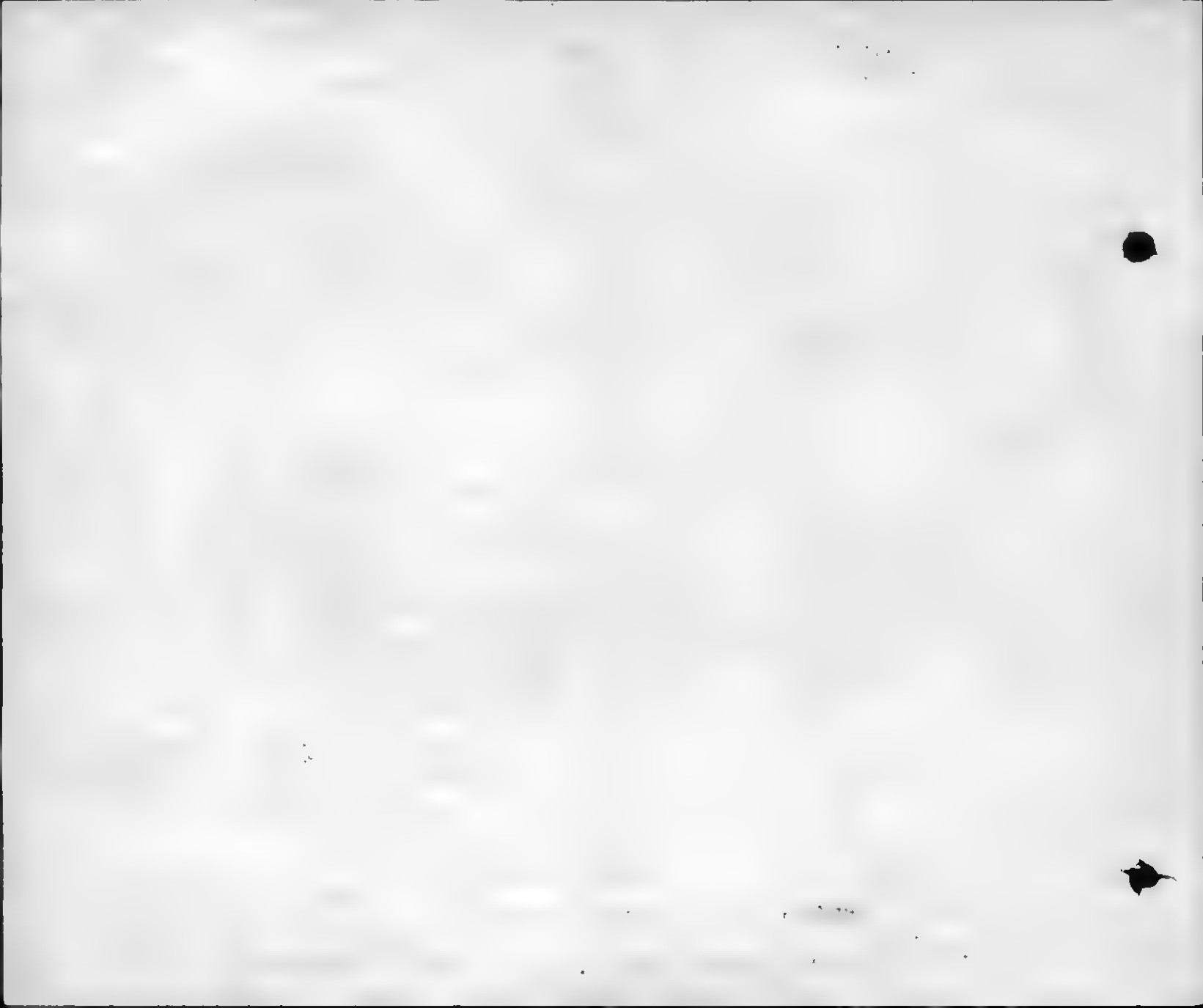
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN b <b>37 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center</b>		2. USUAL RESIDENCE (Where deceased lived, if different residence before admission) a. STATE <b>New Jersey</b> b. COUNTY <b>East Orange</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>139 North Arlington Avenue</b> d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <b>CHARLES JOHN BACHMAN</b>		4. DATE OF DEATH <b>November 14, 19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 13, 1906</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		9b. AGE (In years if UNDER 1 YEAR; if UNDER 24 HRS., last birthday) <b>55 yrs</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Education</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pennsylvania</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Paul Bachman</b>		14. MOTHER'S M A DEN NAME <b>Nellie Bailey</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Not Available</b>	
17. INFORMANT <b>The Medical Record</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) <b>Ventricular Fibrillation</b> DUE TO (b) <b>Aortic Insufficiency</b> DUE TO (c) <b>Rheumatic Heart Disease - Inactive</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Low urinary tract obstruction (Prostatic hypertrophy)</b>	
19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>20 min.</b> <b>20 years</b> <b>20 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>19 61</b> Hour a.m. <b>10</b> p.m. <b>10</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>xx</b> (this hospital) attended the deceased from <b>October 8, 19 61</b> to <b>November 14, 1961</b> , that <b>h</b> (we) last saw the deceased alive on <b>Nov. 14, 19 61</b> , and that death occurred at <b>8:10A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>H. Douglas Clark, MD</b>		22b. DATE SIGNED <b>November 14, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. Douglas Clark</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit 11-15-61</b>		23b. DATE THEREOF <b>Great Valley Presby. Cem. Malvern, Penna.</b>	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>		25a. REC'D BY REGISTRAR <b>DA NOV 16 '61</b>	
ADDRESS <b>Bethesda, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12748						12735					
1. PLACE OF DEATH a. COUNTY <u>Maryland</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Unknown</u> c. LENGTH OF STAY IN 1b <u>CA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Unknown</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>XXXX Park</u> d. STREET ADDRESS <u>4411 Tuckerman Ave</u>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Henry C. Baird</u> 4. DATE OF DEATH Month Day Year <u>November 2, 1961</u>						5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>July 5, 1945</u> 9. AGE (In years last birthday) <u>16 yrs.</u> IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Allen, Texas</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>						13. FATHER'S NAME <u>Henry C. Baird</u> 14. MOTHER'S MAIDEN NAME <u>Sera Litten</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>440-01-3466W</u> 17. INFORMANT <u>Dr. J. B. Snow</u> Address <u>7950 New Hampshire Ave</u>						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> DUE TO (b) <u>OBESITY</u> DUE TO (c) <u>MARKED</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>GOUT, CHRONIC</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> to <u>2 Nov. 1961</u> , that (I) (we) last saw the deceased alive on <u>2 Nov. 1961</u> , and that death occurred at <u>3:30 A.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>L.B. Snow</u> 22c. PHYSICIAN'S NAME (Type) <u>Lee B. Snow</u>						22b. DATE SIGNED <u>11/2/61</u> 22d. ADDRESS <u>7950 New Hampshire Ave</u> 22e. (State) <u>Virginia</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Nov 6, 1961</u>		23c. NAME OF CEMETERY OR CREMATOR <u>Columbia Gardens</u>				23d. LOCATION (City, town or county) (State) <u>Arlington Va</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville Md.</u>						25a. REC'D BY REGISTRAR DATE <u>NOV 9 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			



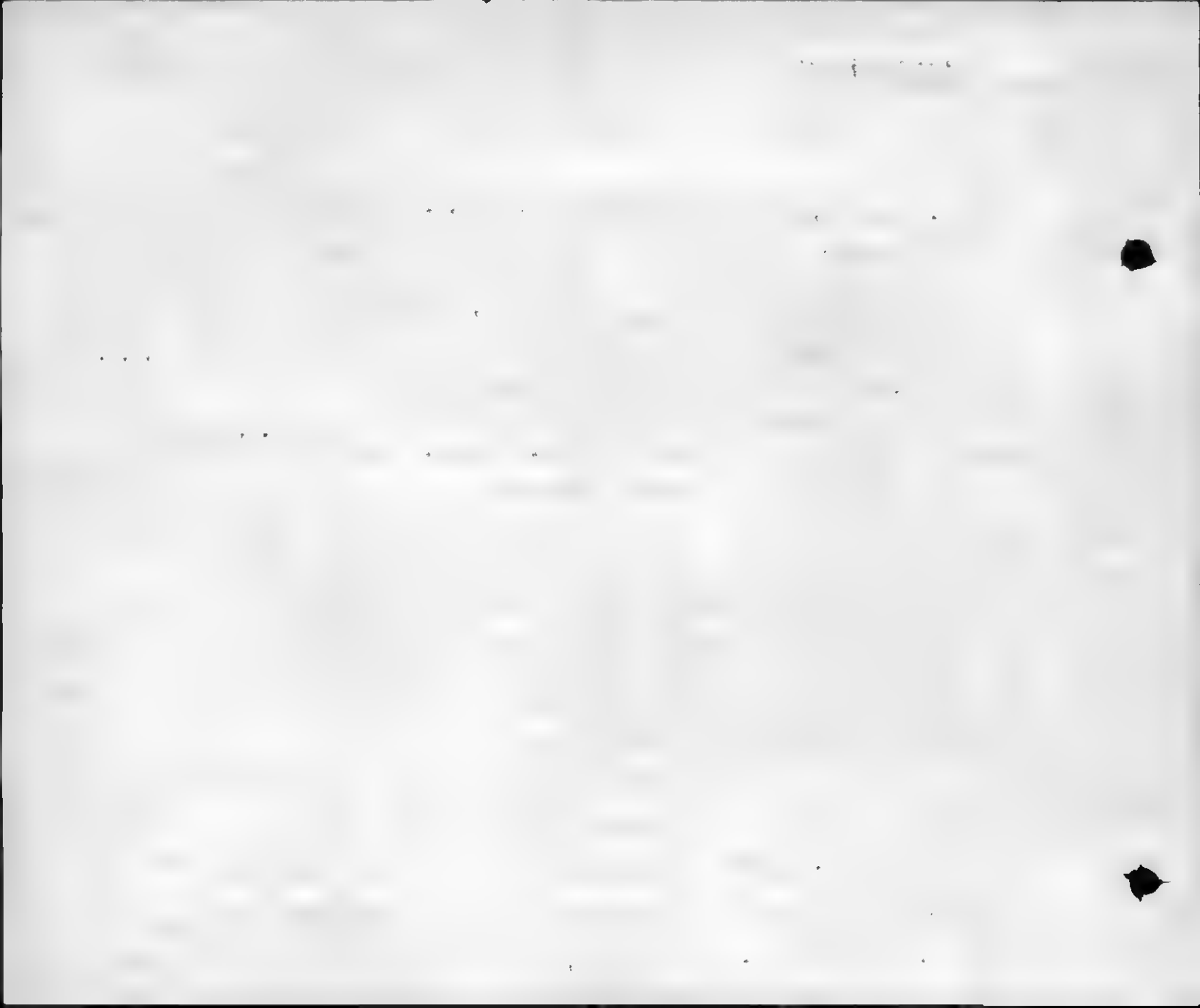
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FOR STATE  
HEALTH DEPT.

TO CITY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12736

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>MARYLAND</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>709 So. Belgrade, Kemp Mill Estates</b>					
3. NAME OF DECEASED (Type or print) <b>Edgar</b>		First <b>C</b>		Middle	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant Own store</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Illinois</b>	
13. FATHER'S NAME <b>Samuel Barnes</b>		14. MOTHER'S MAIDEN NAME <b>Emma Frenthrup</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Verna E. Barnes</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: a <b>History of previous heart disease</b> 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19____ 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D. EXAMINER'S NAME (Type) <b>FRANK J. BROSCART</b> DATE SIGNED <b>11/21/61</b> 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>TRANSIT-BURIAL 11/27/61</b> 22b. DATE THEREOF <b>11/27/61</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Riverview Cemetery</b> 22d. LOCATION (City, town, or country) (State) <b>Portland Oregon</b> 23. FUNERAL DIRECTOR <b>Raymond A Ziska</b> 24b. REC'D BY REGISTRAR <b>NOV 22 '61</b> 24c. REGISTRAR'S SIGNATURE <b>Carlton S. Kline</b> 24a. ADDRESS <b>8434 GEORGIA AVENUE</b> <b>WARNER E. PUMPHREY, INC. SILVER SPRING, MARYLAND</b>					



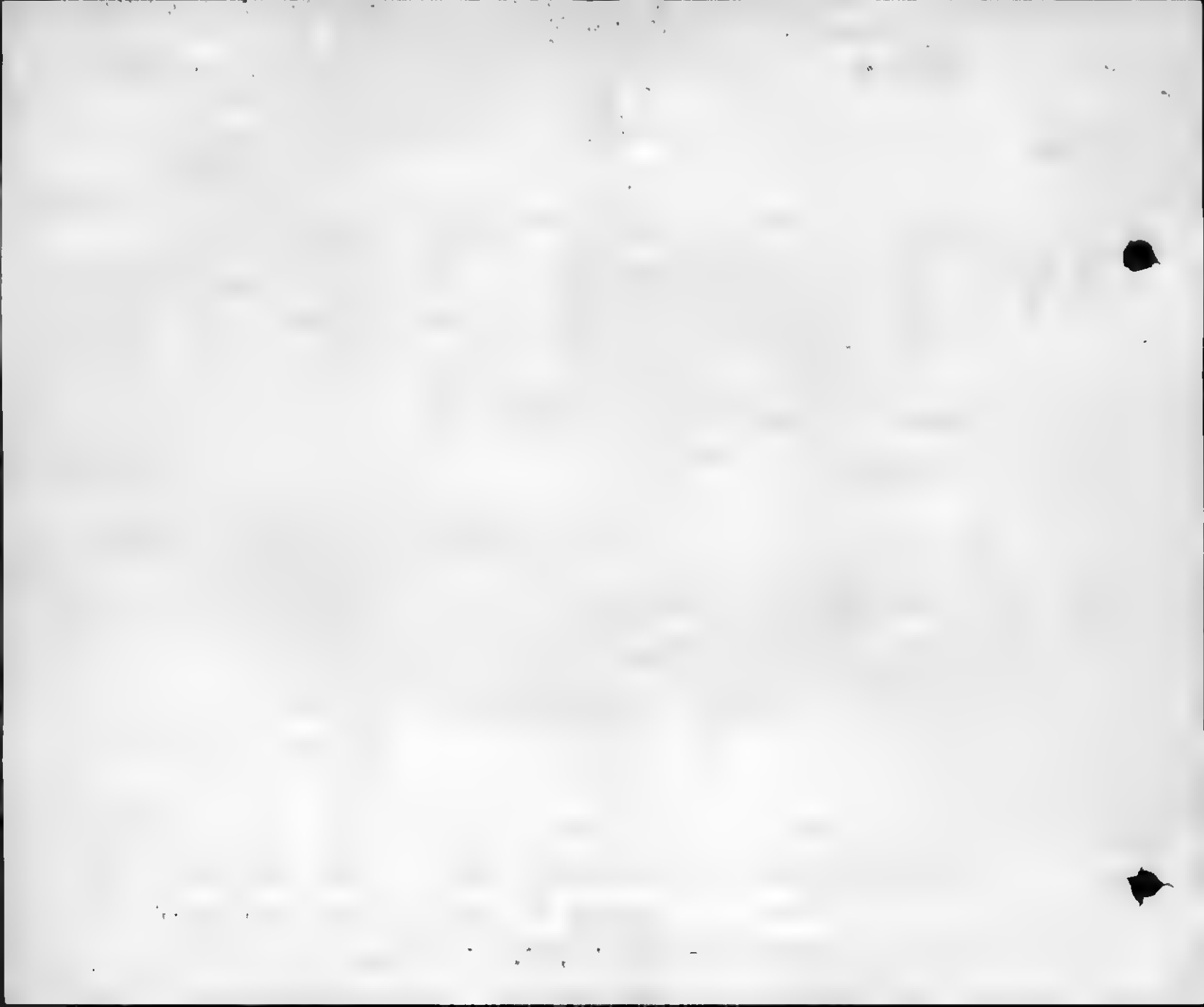
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FOR STATE  
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
12750 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12737

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germananton - R-2</u> c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Seneca Rd.</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montg.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germananton - R-2</u> d. STREET ADDRESS <u>Seneca Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Joseph Henry Beach Jr.</u> SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>8-3-59</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>2</u> yrs. IF UNDER 1 YEAR: Months <u>2</u> Days <u>23</u> IF UNDER 24 HRS.: Hours <u>18</u> Mins. <u>00</u>		4. DATE OF DEATH <u>Nov 23 1961</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> 11. BIRTHPLACE (State or foreign country) <u>MD</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>		13. FATHER'S NAME <u>John Henry Beach</u> 14. MOTHER'S MAIDEN NAME <u>James E. Lowery</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give service) <u>No</u> 16. SOCIAL SECURITY NO. <u>Joe L. Beach</u> 17. INFORMANT <u>John L. Beach</u> Address <u>Stim 2</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE: <u>Asphyxia</u> (b) DUE TO: <u>Upper Respiratory Infection</u> (c) DUE TO: <u>475X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>18 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
21. ACTUAL SIGNATURE <u>Frank J. Blaszczak</u> M.D. EXAMINER'S NAME (Type) <u>FRANK J. BLASZCZAK</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASS. STANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>11-23-61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/26/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Darnestown Church Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Darnestown, Montg., Maryland</u>	
23. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home-</u> ADDRESS <u>1331 E. Montg. Ave. Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 27 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>	



13  
FOR STATE  
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
12751 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12738

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>1 yr</u>				d. STREET ADDRESS <u>1416 Flora Terrace</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Roy</u>		First		Middle		Last	
4. DATE OF DEATH <u>Nov 18 1961</u>		Month		Day		Year	
5. SEX <u>male</u>		6. COLOR OF RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-13-95</u>	
9. AGE (in years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Heurich Brewery</u>			
11. BIRTHPLACE (State or foreign country) <u>va</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.C</u>			
13. FATHER'S NAME <u>George Beasley</u>				14. MOTHER'S MAIDEN NAME <u>Molly Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes WW-1</u>				16. SOCIAL SECURITY NO. <u>578-07-7442</u>			
17. INFORMANT <u>Mildred E. Beasley (wife)</u>				Address <u>Stn 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertension</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>C. A. Left lung - 2 yr</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>11/22/61</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery Arlington Virginia</u>				22d. LOCATION (City, town, or country) (State) <u>11-18-61</u>			
23. FUNERAL DIRECTOR <u>Raymond A. Ziska</u>				24a. REC'D BY REGISTRAR <u>24b. REGISTRAR'S SIGNATURE</u>			
24b. REGISTRAR'S SIGNATURE <u>Raymond E. Pumphrey</u>				DATE <u>NOV 21 '61</u>			



TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V.S. A15M  
SM 9/60

FOR STATE  
HEALTH DEPT.

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
12752 12739									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) e. STATE <u>md</u> b. COUNTY <u>Montg</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bluesy</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> <u>maun club</u>				
c. LENGTH OF STAY IN 1b <u>D.O.A.</u>					d. STREET ADDRESS <u>14631 Crossway Rd</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montg Gen Hosp</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Humphrey Beckett</u>					4. DATE OF DEATH <u>Nov 2 1961</u>				
5. SEX <u>male</u>					6. COLOR OR RACE <u>white</u>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>7-1-1878</u>					9. AGE (In years last birthday) <u>83</u> yrs.				
8. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SE Gen Ret</u>				
10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <u>lanham md.</u>				
12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>					13. FATHER'S NAME <u>Humphrey Beckett</u>				
14. MOTHER'S MAIDEN NAME <u>Anna Lanham</u>					15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				
16. SOCIAL SECURITY NO. <u>10-26-12</u>					17. INFORMANT <u>Margaret Murray (daughter)</u> <u>Elmer</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> <u>Cornary occlusion</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED <u>11-2-61</u>				
Address (Street, city, town, or county)									
22a. BURIAL, CREMATION, REMOVAL (Specify) <input checked="" type="checkbox"/> Burial					22b. DATE THEREOF <u>11/6/61</u>				
22c. NAME OF CEMETERY OR PLACE OF BURIAL <u>Whitfield Church</u>					22d. LOCATION (City, town, or county) (State) <u>Lanham, Md.</u>				
23. FUNERAL DIRECTOR <u>Francis Gasch's Sons</u>					ADDRESS <u>Hyattsville, Md.</u>				
24a. REC'D BY REGISTRAR <u>NOV 6 '61</u>					24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

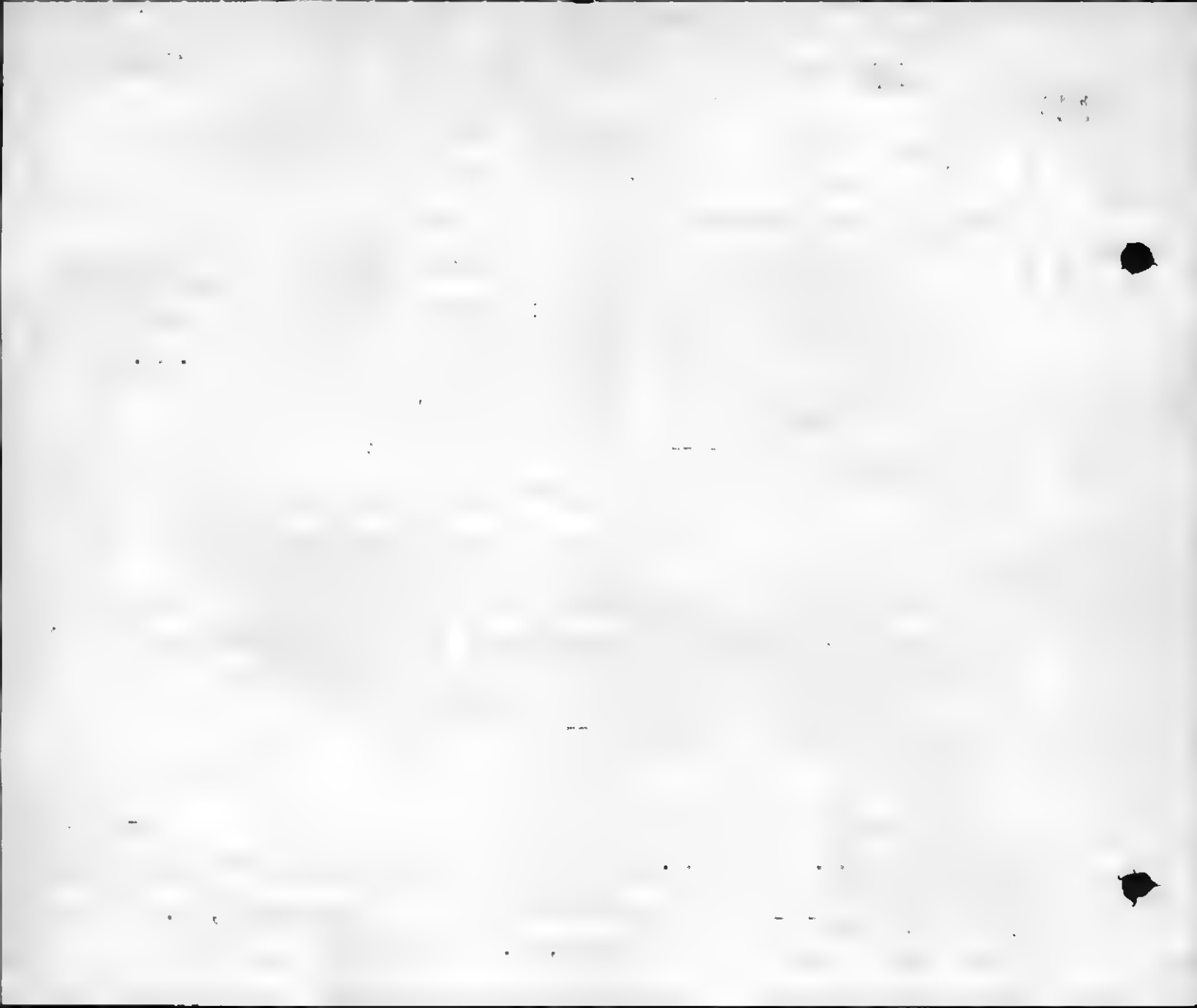
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12753

12740

<b>1. PLACE OF DEATH</b> a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN it 5 weeks d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X BROOKEVILLE d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last CHARLES EDWARD BENSON DEATH 11 22 19 61		<b>4. DATE</b> Month Day Year 11 22 19 61	
<b>5. SEX</b> MALE	<b>6. COLOR OR RACE</b> WHITE	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> 12/8/67
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) RETIRED		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> Farmer	
<b>13. FATHER'S NAME</b> JAMES BENSON		<b>14. MOTHER'S MAIDEN NAME</b> MARY ALLNUTT	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) --		<b>16. SOCIAL SECURITY NO.</b> --	
<b>17. INFORMANT</b> HOSPITAL RECORDS		Address	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Congestive heart failure Conditions, if any, which gave rise to immediate cause (b) arteriosclerotic Cardiovascular Disease (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Tumor of sigmoid colon (prob carcinoma)			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18) --	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. 19		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) --		<b>20f. (City or town)</b> (County) (State) --	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> 10/16, 1961, <b>to</b> 11/22, 1961, <b>that (I) last saw the deceased alive on</b> 11/21, 1961, <b>and that death occurred at</b> 9A.M. <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> J.P. Martin, M.D.		<b>22b. DATE SIGNED</b> 11-22-61	
<b>22c. PHYSICIAN'S NAME</b> (Type) J.P. MARTIN, M.D.		<b>22d. ADDRESS</b> MEDICAL CENTER SANDY SPRING, MARYLAND	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) Burial		<b>23b. DATE THEREOF</b> 11-25-61	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> Salem Cemetery		<b>23d. LOCATION</b> (City, town or county) (State) Brookeville, Md.	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> Francis X. Barber		<b>25a. REC'D BY REGISTRAR</b> DATE NOV 29 '61	
<b>25b. REGISTRAR'S SIGNATURE</b> Curtis L. Kline			



16  
FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

12741

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>18 Takoma Park</u>	
d. STREET ADDRESS <u>7520 Maple Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Virginia Lynne Briggs</u>		4. DATE OF DEATH Month <u>nov</u> Day <u>25</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-16-43</u>
9. AGE (In years last birthday) <u>18</u> yrs.		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>10</u>	
11. IF UNDER 24 HRS. Hours <u>11</u> Min. <u>10</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Temple E. Briggs</u>		14. MOTHER'S MAIDEN NAME <u>Mary Wells</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>HOOF RECORD</u>	
17. INFORMANT <u>HOOF RECORD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Continued Cerebral Contusion + laceration</u> DUE TO (b) <u>Fracture of skull</u> DUE TO (c) <u>Auto Accident</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>Acute Bacterial meningitis</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>Was passenger in car which left highway &amp; struck a tree</u>			
20b. TIME OF INJURY Month, Day, Year <u>3-11-23-1961</u>		20c. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>		20e. (City or town) <u>Silver Spring-Montg</u> (County) <u>md</u> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Injury <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>11-26-61</u>	
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 28, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or country) (State) <u>PRINCE GEORGES Co. Md.</u>	
23. FUNERAL DIRECTOR <u>254 Carroll St NW</u>		24a. REC'D BY REGISTRAR <u>NOV 28 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hester</u>			



12755

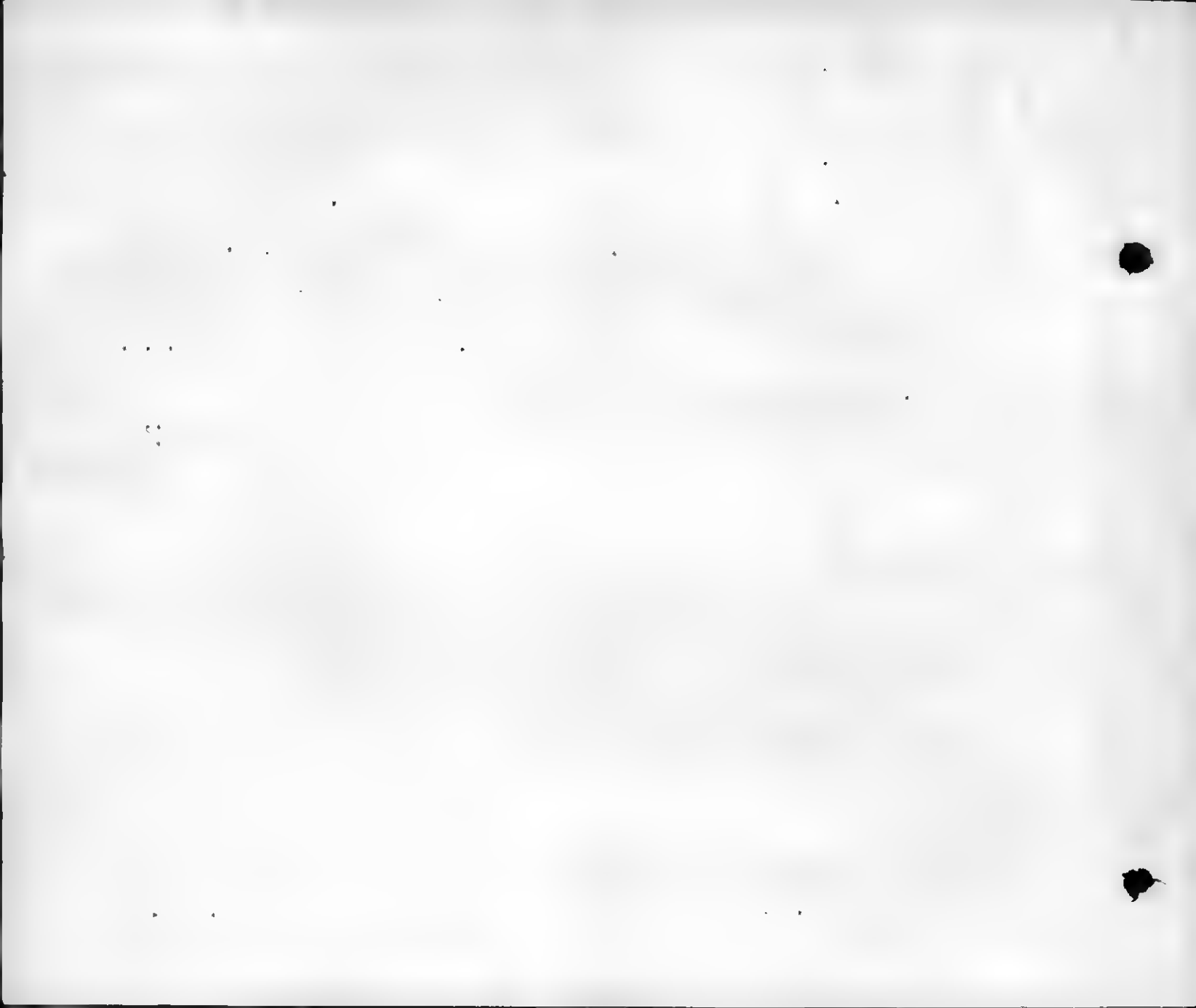
## CERTIFICATE OF DEATH

Reg. Dist. No. 2742

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>123 Grafton St.</u>		d. STREET ADDRESS <u>123 Grafton St.</u>	
3. NAME OF DECEASED (Type or print) First <u>MAY</u> Middle <u>C.</u> Last <u>BIRD</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>25</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 21, 1868</u>
9. AGE (In years last birthday) <u>93</u> yrs.		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pa.</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John A. Clarke</u>		14. MOTHER'S MAIDEN NAME <u>Martha Dillinger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Miss Elizabeth Bird, 123 Grafton St., Chevy Chase, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>  </u> Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1949</u> to <u>Nov. 25</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Nov. 23</u> , 19 <u>61</u> , and that death occurred at <u>4:00</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Delwitt E. DeLauter</u>		DATE SIGNED <u>11-25-61</u>	
PHYSICIAN'S NAME (Type) <u>Delwitt E. DeLauter, M.D.</u>		M.D. <u>3848 Porter St. N.W. Wash. D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>Nov. 25, 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Bladensburg Rd., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cherry Chase Funeral Home</u>		24a. REC'D BY REGISTRAR <u>Nov 27 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hume</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

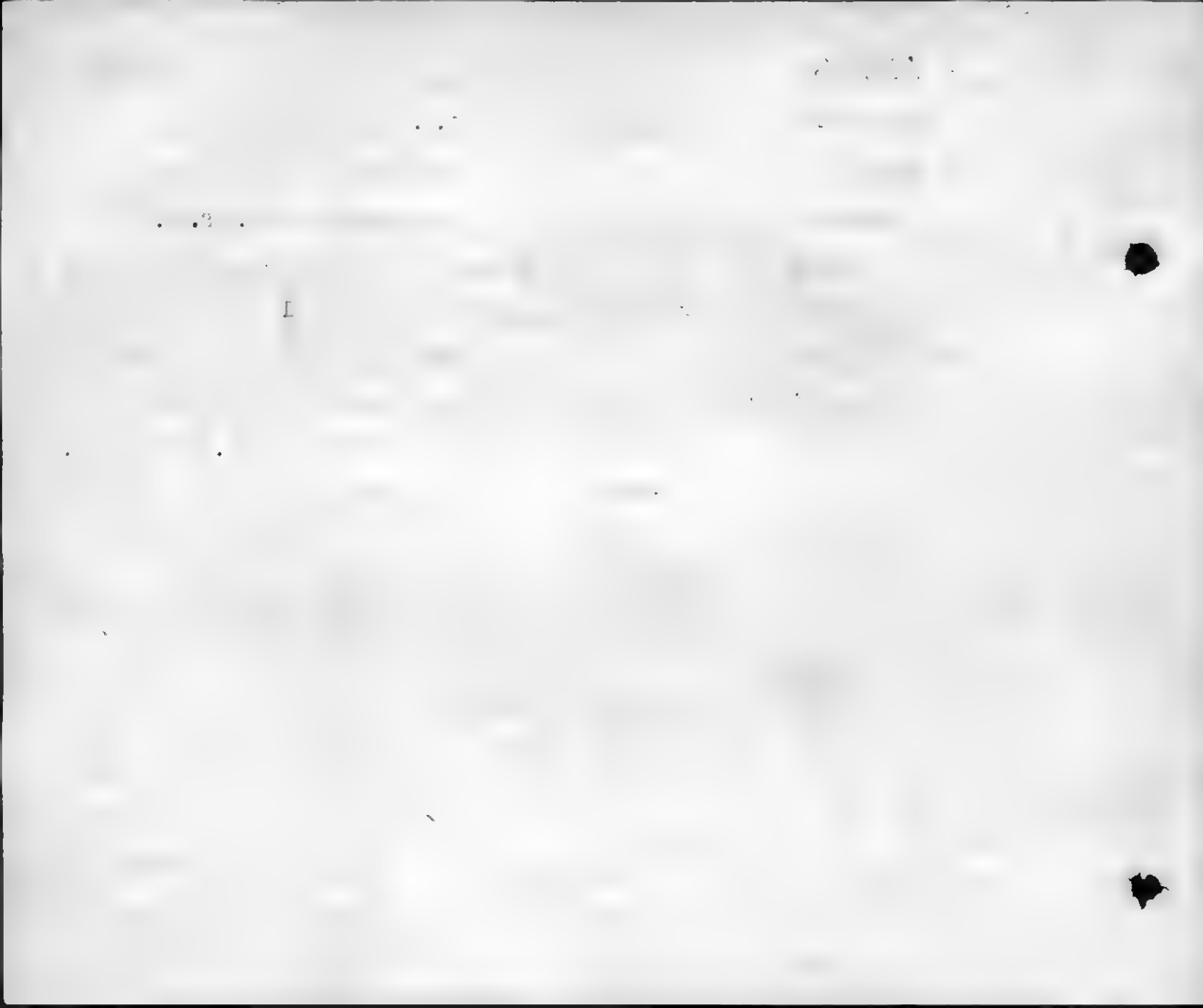
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO PHYSICIAN OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN b. <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban</b>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47X-3</b> d. STREET ADDRESS <b>1903 Minnesota Ave., S. E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <b>Joseph Birnman</b> First Middle Last <b>5. SEX</b> <b>Male</b> <b>6. COLOR OR RACE</b> <b>White</b> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired - Carpenter</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Russia</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>						<b>4. DATE OF DEATH</b> <b>November 30, 1961</b> Month Day Year <b>9. AGE</b> In years <b>71</b> yrs. <b>10. DATE OF BIRTH</b> <b>Feb. 12, 1890</b> If UNDER 1 YEAR: Months Days Hours Min. <b>13. FATHER'S NAME</b> <b>Jout Birnman</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>Sylvia Libby</b> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> <b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> <b>Jack Birnman, 11010 Horde St. Wheaton, Md.</b> <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>151X</b> DUE TO <b>Carcinoma of Stomach</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): <b>Carcinoma of Liver</b> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> Hour a.m. p.m. <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b> <b>21. I certify</b> that (I) (this hospital) attended the deceased from <b>Jan 1951</b> to <b>Nov 30, 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov 29, 1961</b> , and that death occurred at <b>9 A.M.</b> from the causes and on the date stated above. <b>22a. SIGNATURE</b> <b>Blaine H. Eig</b> <b>22c. PHYSICIAN'S NAME</b> (Type) <b>BLAINE H. EIG</b> <b>22b. DATE SIGNED</b> <b>Nov 30, 1961</b> <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b> <b>23b. DATE THEREOF</b> <b>12-1-61</b> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Mt. Lebanon Cemetery</b> <b>23d. LOCATION</b> (City, town or county) (State) <b>Hyattsville, Maryland</b> <b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Blazynski</b> <b>25a. REC'D BY REGISTRAR</b> <b>DEC 4 '61</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kline</b>					



## CERTIFICATE OF DEATH

Reg. Dist. No. 12744

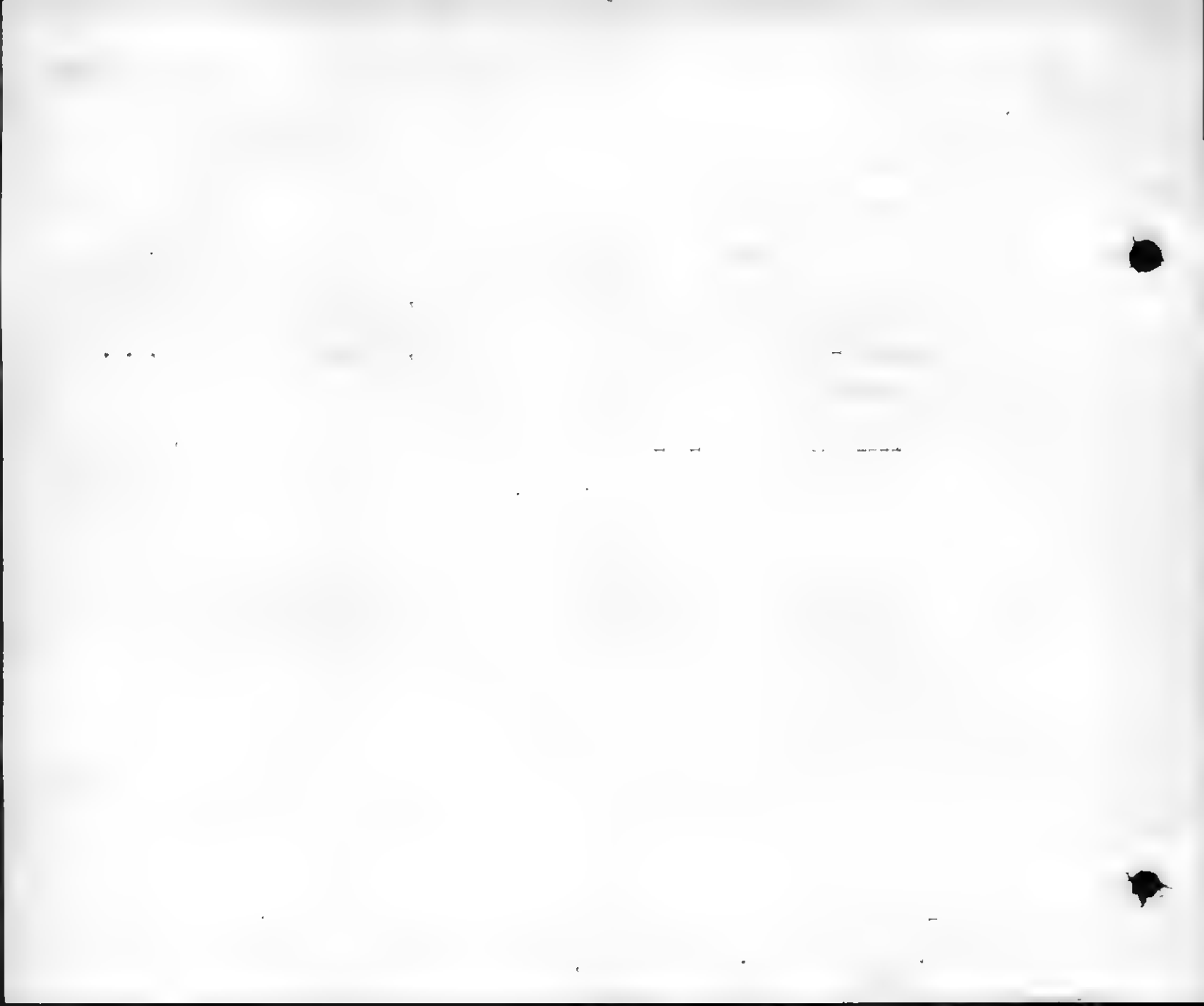
12757

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>MONT.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring 34</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Carroll Hall Nursing Home</b>				d. STREET ADDRESS <b>3204 Clay St. 1</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>John M. Blackburn</b>				4. DATE OF DEATH Month Day Year <b>Nov. 6 1961</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 10, 1887</b>		9. AGE (In years lost birthday) <b>74</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shovel Operator-Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Coal Mines</b>		11. BIRTHPLACE (State or foreign country) <b>Danville, Alabama</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David Blackburn</b>				14. MOTHER'S MAIDEN NAME <b>Isabelle Doss</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>342-05-7687</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				INFORMANT Address <b>Pyatt Funeral Home, Pinckneyville, Illinois</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerosis</b> (c) <b>sen'L yrs.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1-hr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10/29/61</b> to <b>11/6/61</b> , that I last saw the deceased alive on <b>10/29/61</b> , and that death occurred at <b>11 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Donald Nelson</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>10620 Ga. Ave Sil Spg Md 11/6/61</b>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Transit-Burial 11/9/61</b>		<b>11/9/61</b>		<b>Sunset Memorial Cemetery</b>		<b>Duwoin, Illinois</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Pumphrey, Inc.</b>				24a. REC'D BY REGISTRAR <b>NOV 7 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

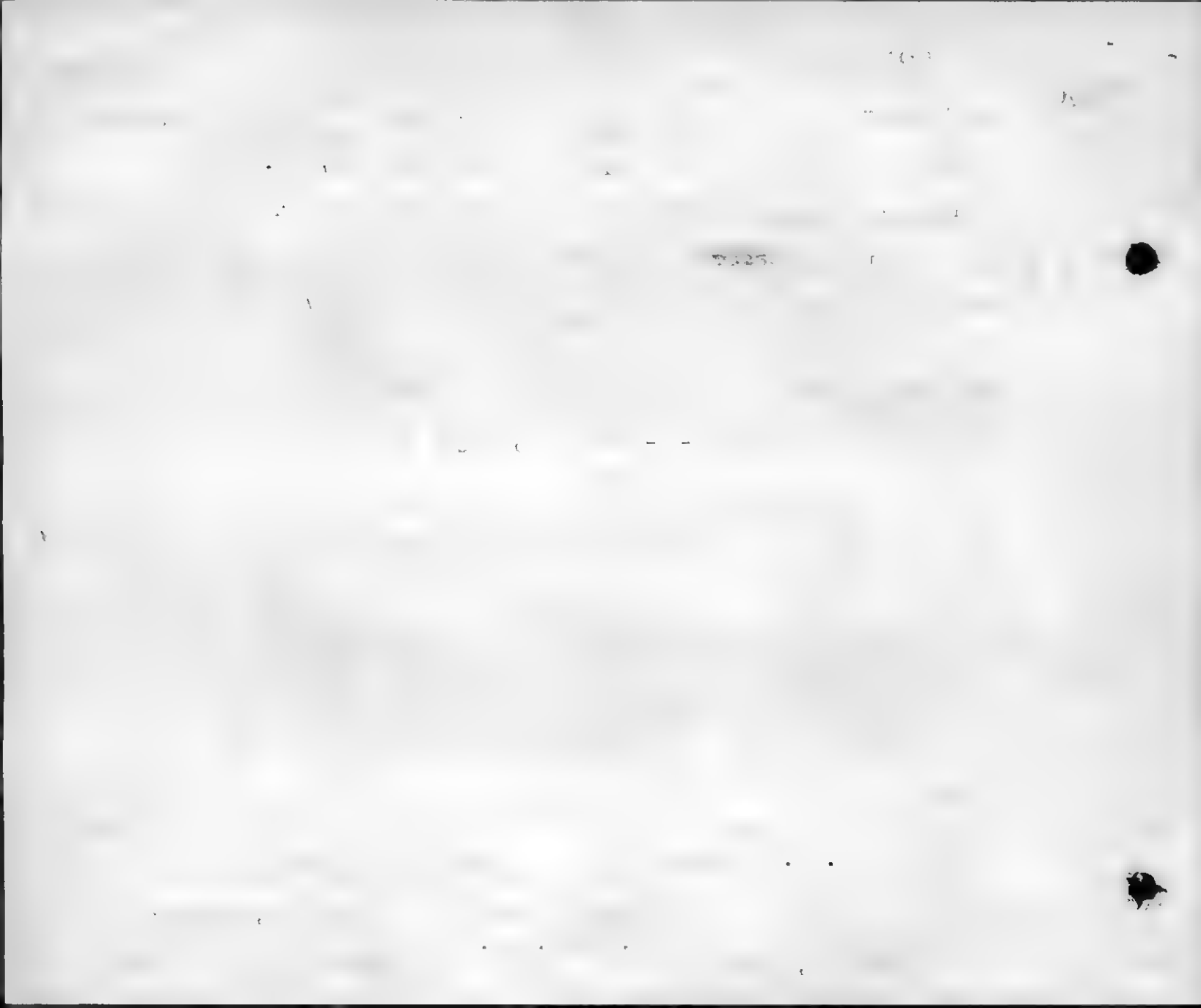
## CERTIFICATE OF DEATH

12758

12745

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b> c. LENGTH OF STAY IN 1b <b>11 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg, Md.</b> d. STREET ADDRESS <b>205 Oakmont Avenue</b>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>Laurette Hetzel Bouchard</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>11 26 1961</b>	
<b>5. SEX</b> <b>female</b>		<b>6. COLOR OR RACE</b> <b>white</b>	
<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>11/9/89</b>	
<b>9. AGE</b> (In years) IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours M.n. <b>72 yrs.</b>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Iowa</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Edward Hetzel</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Alice Belle</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>16. SOCIAL SECURITY NO.</b> <b>265-03-2319-B</b>		<b>17. INFORMANT</b> <b>Hospital Records</b> Address	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>446X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Chronic nephrosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Old cardiovascular disease</b> <b>Chronic pyelonephritis, Congestive heart failure, arteriosclerosis</b> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b> <b>21. I certify that (I) (this hospital) attended the deceased from Nov. 1954, to 11/26, 1961, that (I) (we) last saw the deceased alive on 11/26, 1961, and that death occurred at 2:25 P.M. from the causes and on the date stated above.</b> <b>22a. SIGNATURE</b> <b>G. F. Meadors</b> <b>22c. PHYSICIAN'S NAME</b> (Type) <b>G. F. Meadors</b> <b>22d. ADDRESS</b> <b>Damascus, Maryland</b> <b>22b. DATE, SIGNED</b> <b>11/26/61</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b> <b>23b. DATE THEREOF</b> <b>11/29/61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Arlington National</b> <b>23d. LOCATION</b> (City, town or county) (State) <b>Arlington, Virginia</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Maryland</b>		<b>25a. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>DATE</b> <b>NOV 29 '61</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

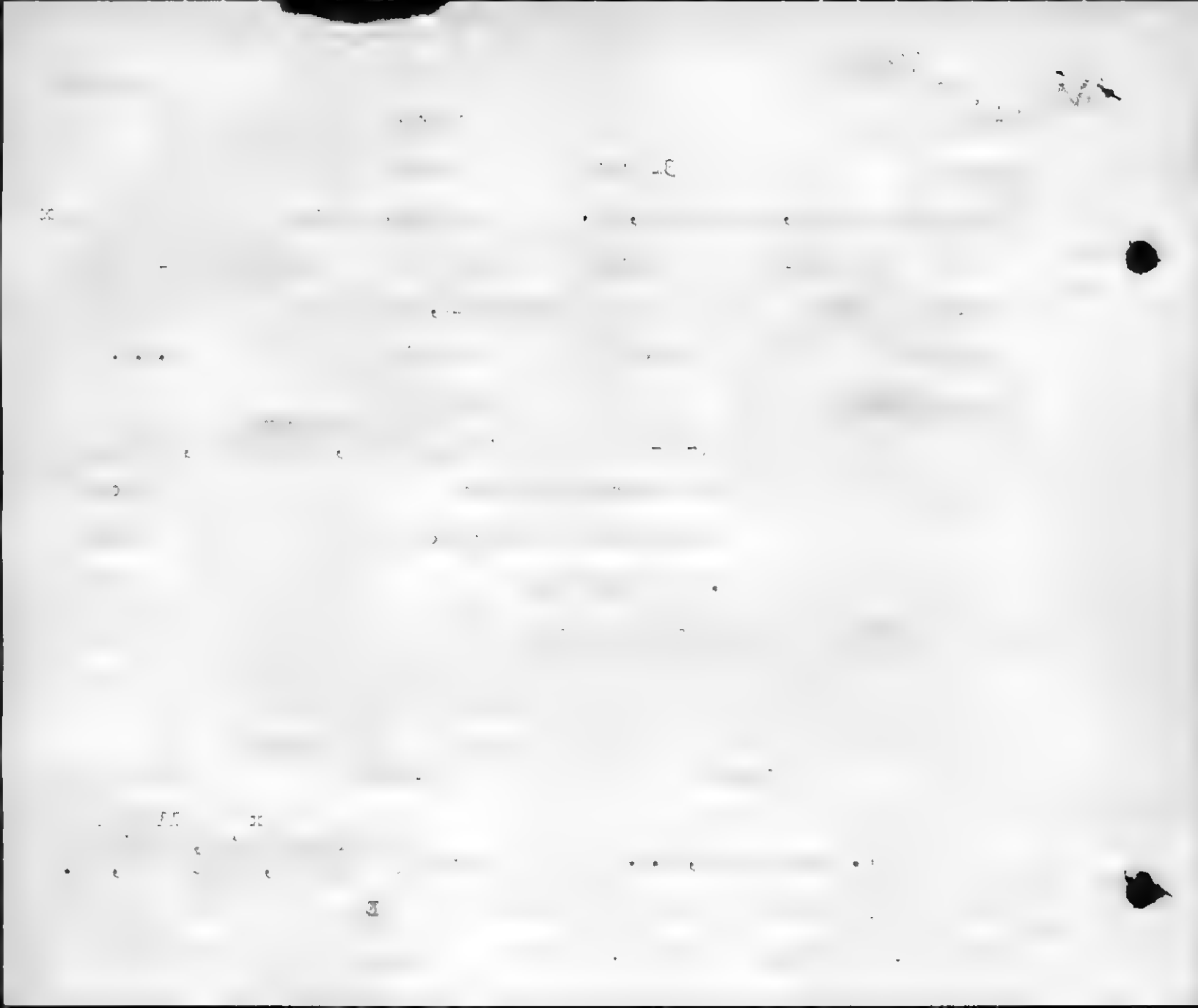
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12759

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>31 days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence prior to admission) a. STATE <b>Florida</b>		b. COUNTY <b>DeLand</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>415 Clara Avenue</b>		d. STREET ADDRESS <b>415 Clara Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Amie Susan Branch</b>		First <b>Amie</b>		Middle <b>Susan</b>		Last <b>Branch</b>		4. DATE OF DEATH Month <b>November</b>		Day <b>2</b>		Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 20, 1895</b>		9. AGE (in years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months <b>66</b>		IF UNDER 24 HRS. Days <b>66</b>		Hours <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>									
13. FATHER'S NAME <b>George Clements</b>		14. MOTHER'S MAIDEN NAME <b>Martha Gibbs</b>													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (fysg:give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>267-38-3884</b>		17. INFORMATION <b>The Medical Record</b>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular collapse</b> <b>053.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Acute Myocardial Infarction</b> (a), stating the underlying cause last. (c) <b>E. Coli Septicemia</b>												INTERVAL BETWEEN ONSET AND DEATH <b>7 hours</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Epidermoid Carcinoma of Vagina</b>												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>October 2, 1961</b>		(County) <b>November 2, 1961</b>		(State) <b>1961</b>					
21. I certify that (I) (this hospital) attended the deceased from <b>October 2, 1961</b> to <b>November 2, 1961</b> , that (I) (we) last saw the deceased alive on <b>November 2, 1961</b> , and that death occurred at <b>12:56 PM</b> from the causes and on the date stated above.															
22a. SIGNATURE <b>J. Kent Trinkle</b>		22b. DATE SIGNED <b>11/2/61</b>		22c. PHYSICIAN'S NAME (Type) <b>J. Kent Trinkle, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit 11/3/61</b>		23b. DATE THEREOF <b>11/3/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oakdale Cemetery</b>		23d. LOCATION (City, town or county) <b>Volusia County, Florida</b>		(State) <b>Florida</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		ADDRESS <b>Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>NOV 6 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12760

## CERTIFICATE OF DEATH

12747

### PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Kensington

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

11209 Upton Drive

### 2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)

a. STATE Maryland

b. COUNTY Montgomery

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Kensington

d. STREET ADDRESS

11209 Upton Drive

e. IS RESIDENCE ON A FARM?  
YES ☐ NO ☒

3. NAME OF DECEASED  
(Type or print)

First  
JAMES

Middle  
B.

Last  
BREEDEN

4. DATE OF DEATH

Month  
Nov. 23,

Day

Year  
19 61

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

Mar. 12, 1889

9. AGE (in years last birthday)

72 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Fireman - Retired

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

U. S.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

578-01-2949-A

17. INFORMANT

Wife  
Mamie L. Breedon

Address

Same as Item 2.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

CHRONIC MYOCARDITIS

DUE TO

420.0  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(b) ARTERIOSCLEROTIC HEART DISEASE

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH  
MONTHS

YEARS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).

CARCINOMA OF PROSTATE WITH METASTASIS TO LUNGS AND BRAIN

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

20c. TIME OF INJURY

Month, Day, Year

Hour a.m.  
p.m.

19

20d. INJURY OCCURRED

While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 5 - 10:45P to 11-23-61, that (I) (we) last saw the deceased alive on 11-21-61, and that death occurred at 10:45P M, from the causes and on the date stated above.

22a. SIGNATURE

JACK SCHUMACHER

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☒

STAFF PHYS. ☐

11/24/61

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

JACK SCHUMACHER, M.D.

22d. ADDRESS

GAITHERSBURG, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

11-27-61

23c. NAME OF CEMETERY OR CREMATORY

Parklawn Cemetery

23d. LOCATION (City, town or county)

Rockville, Maryland

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

ROBERT A. PUMPHREY

ADDRESS

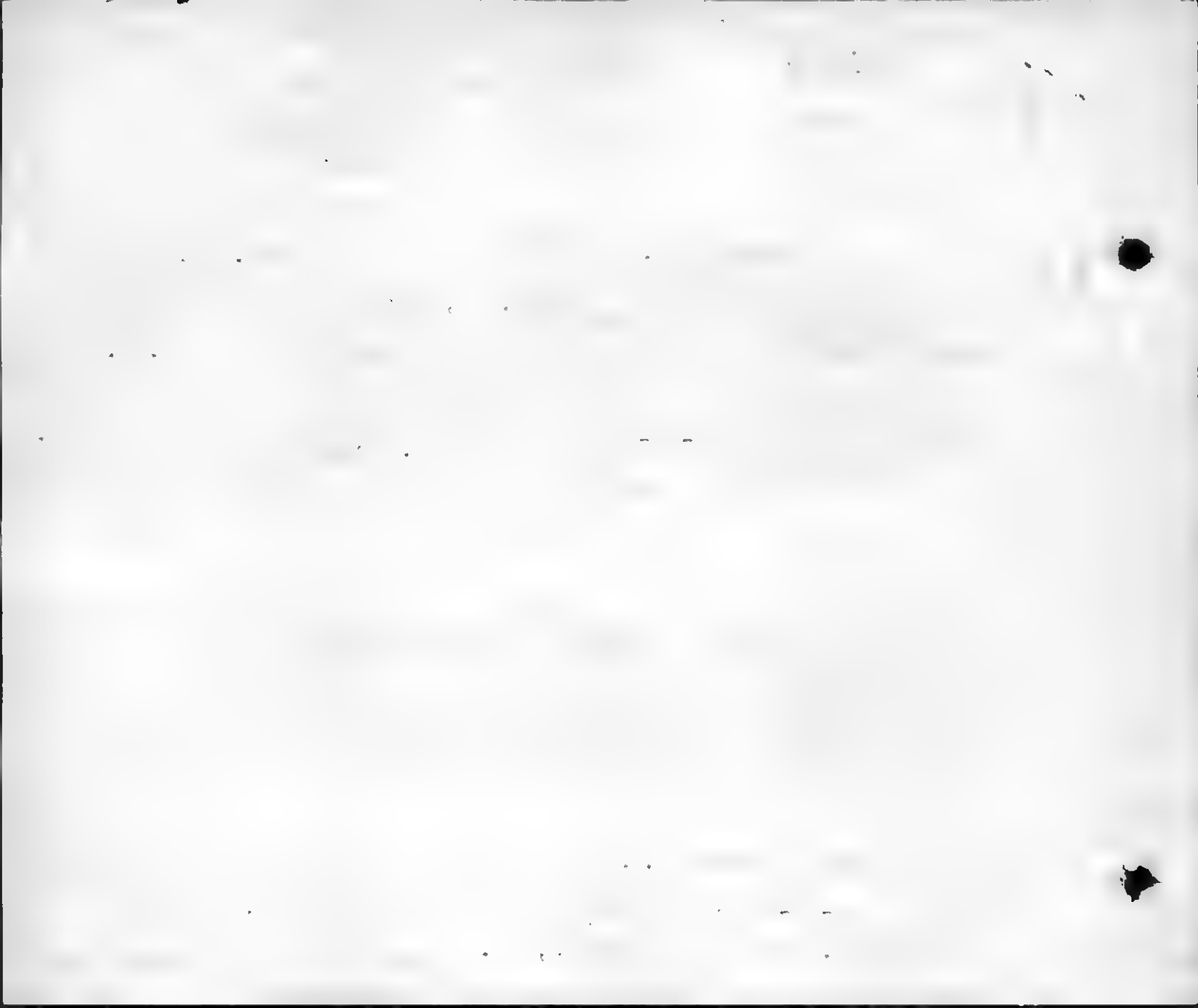
Bethesda, Md.

25a. REC'D BY REGISTRAR

DATE NOV 30 '61

25b. REGISTRAR'S SIGNATURE

William L. House



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

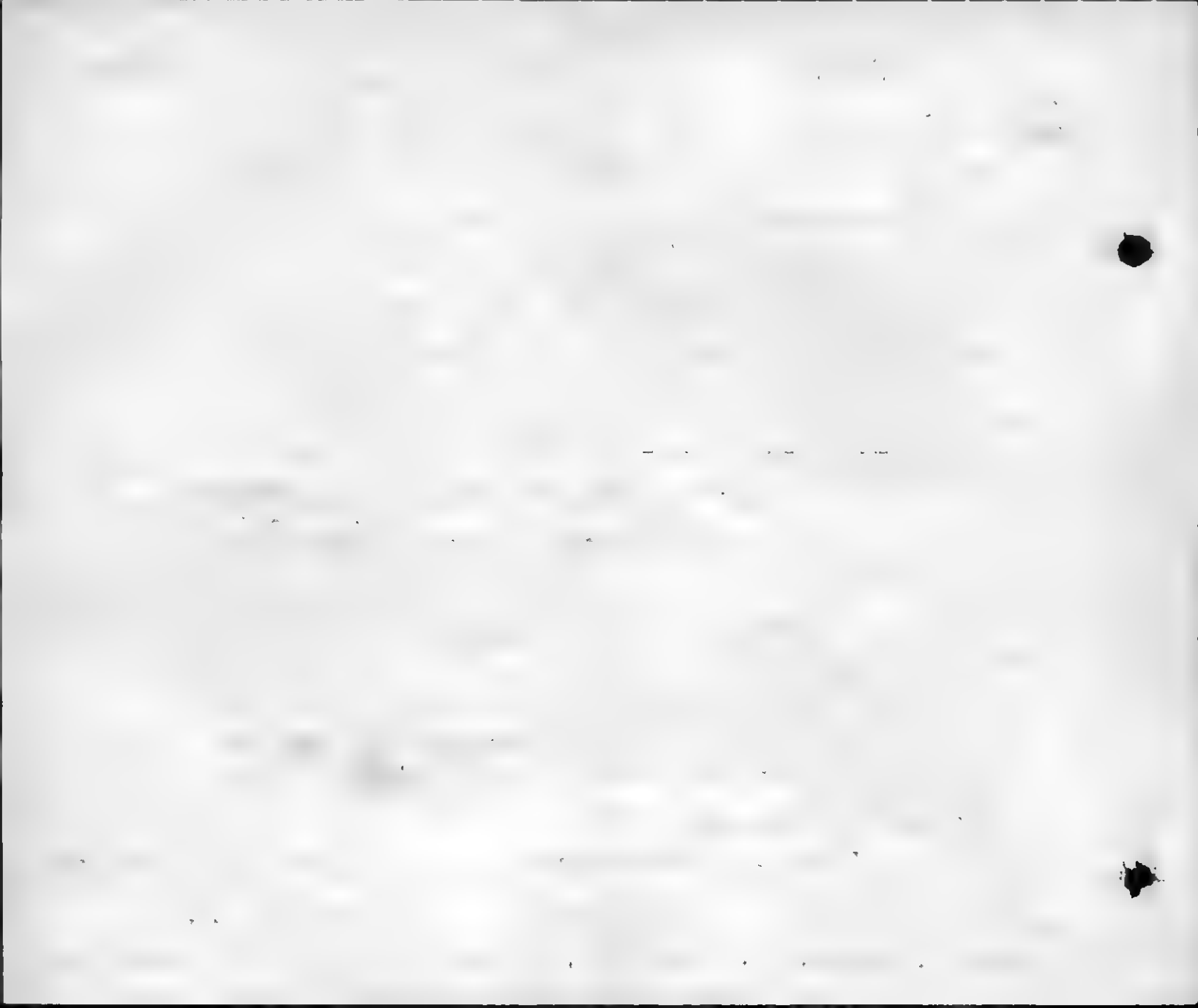
12761

12748

<b>1. PLACE OF DEATH</b> <b>a. COUNTY</b> <u>Montgomery</u> <b>b. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> <b>c. LENGTH OF STAY IN 1b</b> <u>25 days</u> <b>d. NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) <b>a. STATE</b> <u>Maryland</u> <b>b. COUNTY</b> <u>Montgomery</u> <b>c. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) <u>1701 White Oak Dr.</u> <b>d. STREET ADDRESS</b> <u>Silver Spring</u>	
<b>3. NAME OF DECEASED</b> First Middle Last <u>Marie Hall</u> <b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF DEATH</b> <u>Nov. 21 1961</u> <b>9. AGE</b> (In years last birthday) <u>85</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Ohio</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Moses Hall</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Ropp</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>220-34-8061</u> <b>17. INFORMANT</b> <u>Hospital Records</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Congestive Heart failure - Uræmia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Marcel obesity</u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Oct 26, 1961</u> <b>to</b> <u>Nov 21, 1961</u> <b>that (I) (we) last saw the deceased alive on</b> <u>Nov 21, 1961</u> <b>and that death occurred at</b> <u>1:30 P.M.</u> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>J. Marion Bankhead</u> <b>22c. PHYSICIAN'S NAME (Type)</b> <u>J. Marion Bankhead</u>		<b>22b. DATE SIGNED</b> <u>Nov. 21, 1961</u> <b>22d. ADDRESS</b> <u>9241 Cal. Blvd. Silver Spring, Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>23b. DATE THEREOF</b> <u>11/25/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Glenwood Cemetery</u> <b>23d. LOCATION (City, town or county) (State)</b> <u>Washington D.C.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Raymond A. Zisk</u> <b>25a. REC'D BY REGISTRAR</b> <u>DATE NOV 24 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12762

12749

<b>1. PLACE OF DEATH</b> a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WHEATON</b> c. LENGTH OF STAY IN 1b <b>3 MOS.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>11901 Georgia Avenue</b> <b>WHEATON NURSING HOME</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If Institution: Residence before admission) a. STATE <b>WASHINGTON, D. C.</b> b. COUNTY <b>WASHINGTON, D. C.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON, D. C.</b> d. STREET ADDRESS <b>5425 CONNECTICUT AVE. N.W.</b>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>GEORGE HAY BROWN</b> First Middle Last		<b>4. DATE OF DEATH</b> Month <b>11</b> Day <b>21</b> Year <b>1961</b>	
<b>5. SEX</b> <b>MALE</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>	
<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>11/23/1871</b>	
<b>9. AGE</b> (In years last birthday) <b>89</b> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <b>8</b> Days <b>21</b>	
<b>11. IF UNDER 24 HRS.</b> Hours <b>19</b> Min.		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>AMR.</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>SALES</b>	
<b>13. FATHER'S NAME</b> <b>GEORGE HAY BROWN</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>ELIZABETH SACCASKI</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b>		<b>16. SOCIAL SECURITY NO</b> <b>?</b>	
<b>17. INFORMANT</b> Address <b>Records at Nursing Home -- Same # 1</b>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pyelonephritis Chronic</b> (b) <b>Prostatitis</b> (c) <b>Exhaustion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of Item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> Hour a.m. <b>19</b> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>Aug 8, 1961</b> , to <b>Nov 21</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Nov 15</b> , 19 <b>61</b> , and that death occurred at <b>7:45</b> A.M. from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>Thomas C. Thompson</b> M.D.		<b>22b. DATE SIGNED</b> <b>Nov 21 1961</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Thomas C. Thompson</b>		<b>22d. ADDRESS</b> <b>2032 16th St., N.W.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>11/25/1961</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Congressional Cemetery</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Washington, D.C.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>The S.H. Hines Co. - 2901 14th St., N.W.</b>		<b>25a. REC'D BY REG. STR.</b> <b>DATE NOV 24 '61</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Hines</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. The first part of the document is a list of names and addresses, which appears to be a directory or a list of subscribers. The names are written in a cursive script, and the addresses are listed below them.

10. 11. 1917

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12763

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12750

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens</u>				d. STREET ADDRESS <u>5 Magnolia Parkway</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>MARY ROSS YOUNG BROWN</u>				4. DATE OF DEATH <u>Nov. 11 1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 8 1876</u>	9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>DR. PROBY Young</u>				14. MOTHER'S MAIDEN NAME <u>IDA PERRY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>none</u>		17. INFORMANT <u>Hospital records</u>		Address <u>Same as Item #1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 CONGESTIVE HEART FAILURE</u> DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>CEREBRAL THROMBOSIS - MULT. SMALL</u> Conditions if any which gave rise to immediate cause (a), stating the underlying cause last							INTERVAL BETWEEN ONSET AND DEATH <u>4-who</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 23 1961</u> to <u>Nov 11 1961</u> , that (I) (we) last saw the deceased alive on <u>Nov 4 1961</u> , and that death occurred at <u>3:25 PM</u> from the causes and on the date stated above							
22a. SIGNATURE <u>Robert T. Thibadeau</u>				22b. DATE SIGNED <u>Nov 11-61</u>			
22c. PHYSICIAN'S NAME (Type or print) <u>ROBERT T. THIBADEAU</u>				22d. ADDRESS <u>10609 CONCORD ST. KENSINGTON, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>11-13-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City, town, or county) (State) <u>Prince George Co., Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>				ADDRESS <u>Bethesda, Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 14 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

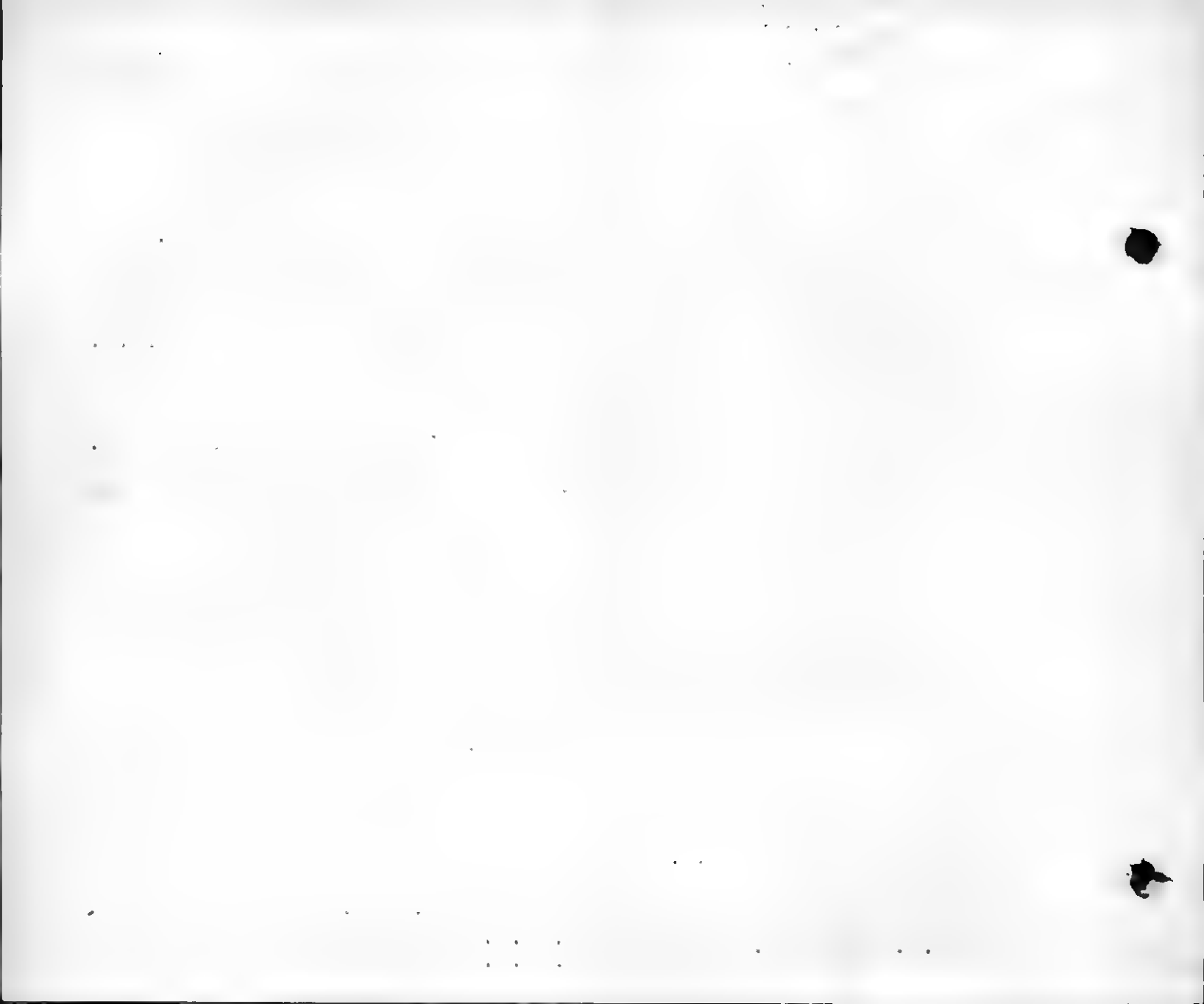
*(Faint handwritten notes at the bottom of the page)*

12764

## CERTIFICATE OF DEATH

Reg. Dist. No. 12751

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>				c. LENGTH OF STAY IN 1b <b>10</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Washington Sanitarium &amp; Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Frieda</b> Middle <b>Brunk</b> Last <b>Brunk</b>				4. DATE OF DEATH Month <b>November</b> Day <b>27</b> , 1961 Year <b>19</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/4/86</b>	
9. AGE (In years last birthday) <b>75</b> yrs		10. IF UNDER 1 YEAR Months <b>75</b> Days <b>75</b> Hours <b>75</b> Min <b>75</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <b>Gottlieb Meisner</b>				14. MOTHER'S MAIDEN NAME <b>Marie Apelt</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>101-03-4686A</b>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>583X</b> DUE TO <b>Hepatic insufficiency</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>10620 Co. Ave, Sil Spg, Md</b> (c) <b>11/26/61</b>				INTERVAL BETWEEN ONSET AND DEATH <b>10620 Co. Ave, Sil Spg, Md</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>11/26/1961</b> to <b>11/27/1961</b> , that I last saw the deceased alive on <b>11/26/1961</b> , and that death occurred at <b>10:45 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Donald Nelson</b>				ADDRESS (Street, city or town, state) <b>10620 Co. Ave, Sil Spg, Md</b>			
DATE SIGNED <b>11/27/61</b>				DATE SIGNED			
PHYSICIAN'S NAME (Type) <b>Donald Nelson, M.D.</b>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>				22b. DATE THEREOF <b>11/30/61</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>National Memorial Pk,</b>				22d. LOCATION (City, town or county) (State) <b>Cem. Falls Church, Va.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>				24. REC'D BY REGISTRAR <b>NOV 30 '61</b>			
ADDRESS <b>2901 14th St. N.W. Washington 9, D.C.</b>				24b. REGISTRAR'S SIGNATURE <b>Charles S. Hines</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12765

12752

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Texas</u> b. COUNTY <u></u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brownsville</u>		
c. LENGTH OF STAY IN 1b <u>18 days</u>			d. STREET ADDRESS <u>Qtr. 169, Ft. Brown</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Naval Hospital</u>					
<b>3. NAME OF DECEASED</b> (Type or print) <u>Robert</u>		First <u>Stephen</u> Middle <u>Burpo Jr.</u> Last <u></u>		<b>4. DATE OF DEATH</b> Month <u>November</u> Day <u>17,</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 1, 1915</u>	9. AGE (in years last birthday) <u>46 yrs.</u>	10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Naval Officer</u>			11. BIRTHPLACE (County & State or foreign country) <u>Massachusetts</u>		
10b. KIND OF BUSINESS OR INDUSTRY <u>Teacher</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Robert Stephen Burpo</u>			14. MOTHER'S MAIDEN NAME <u>Louise B. Carr</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>			16. SOCIAL SECURITY NO. <u>034 07 7311</u>		
17. INFORMANT <u>WV II, Korea</u>			Address <u>WIFE: Dorothy A. Burpo, Same as #2</u>		
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA BRAIN</u> DUE TO <u>1914</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>SQUAMOUS CELL CARCINOMA NECK</u> (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. INTERVAL BETWEEN ONSET AND DEATH <u>21 DAYS</u> <u>7 YEARS</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (X) (this hospital) attended the deceased from <u>October 31, 1961</u> to <u>November 17, 1961</u> , that (X) (we) last saw the deceased alive on <u>November 17, 1961</u> , and that death occurred at <u>6:30 AM</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>G.W. Taylor Jr.</u>					
22c. PHYSICIAN'S NAME (Type) <u>G.W. TAYLOR JR., CAPTAIN MC USN</u>					
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					
22d. ADDRESS <u>U.S. Naval Hospital, Bethesda, Md</u>					
22b. DATE SIGNED <u>November 17, 1961</u>					
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>21 Nov 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>	
23d. LOCATION (City, town or county) <u>Arlington, Va</u>		(State)		25a. REC'D BY REGISTRAR <u>RDV 21 '61</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Pumphrey, Bethesda, Md.</u>					
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

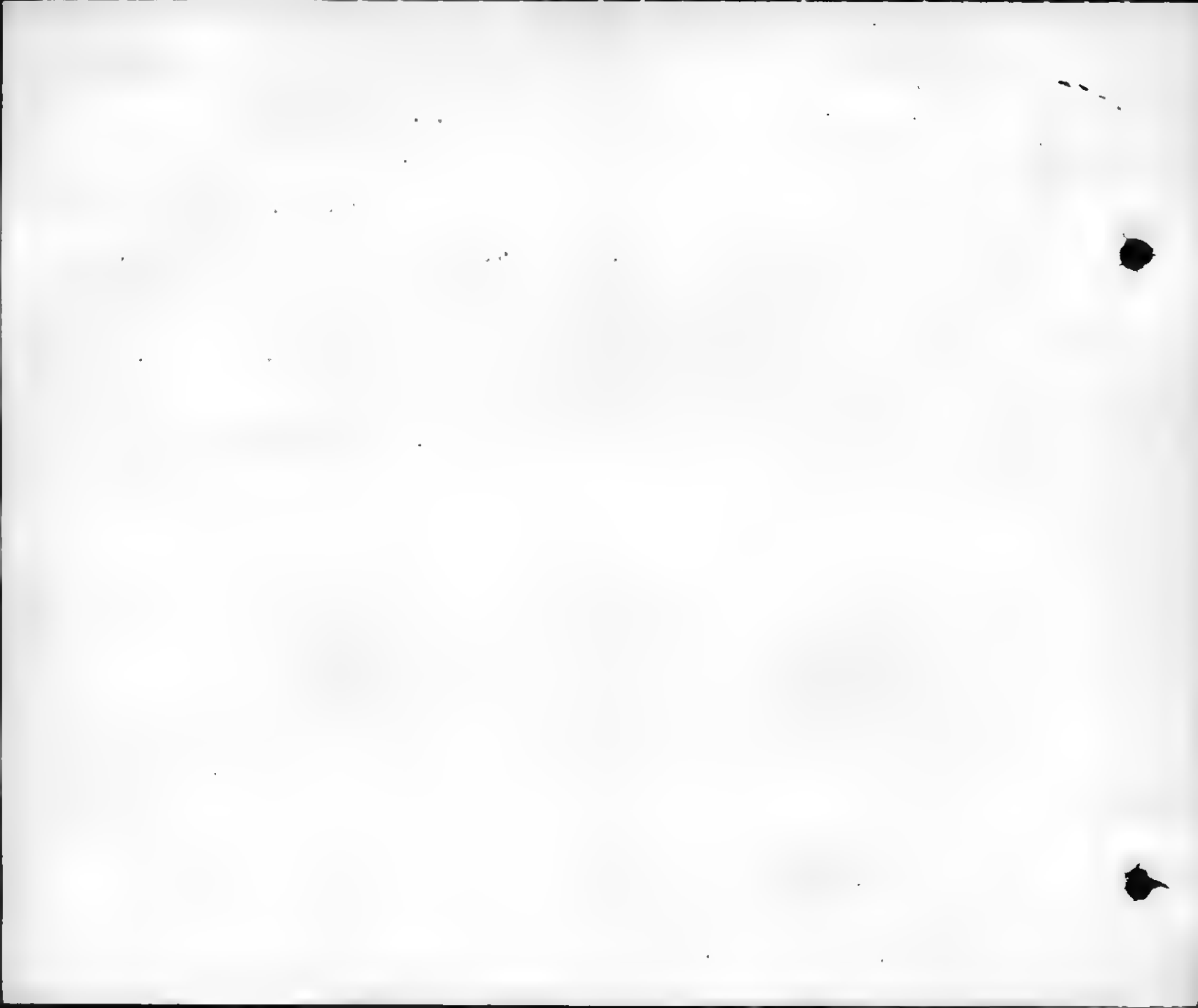
12766

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12753

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>10½ days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>W.</b> Last <b>Burrell</b>		4. DATE OF DEATH Month <b>November</b> Day <b>6</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/19/78</b>
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>17</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Navy Architect</b>	
11. BIRTHPLACE (State or foreign country) <b>Sunberry, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Andrew Burrell</b>		14. MOTHER'S MAIDEN NAME <b>Sue Sadler</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Margaret H. Burrell-Wife-same 2d</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal Shut Down Cardiovascular</b> <b>541.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Post-operative - Sp. for. by abdominal aortic</b> INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10/26</b> 19 <b>61</b> to <b>11/6</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>11/6</b> 19 <b>61</b> , and that death occurred at <b>9 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Walter Atkinson</b>		22b. DATE SIGNED <b>11/6/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Walter Atkinson</b>		22d. ADDRESS <b>1835 Eye St. N. W., Wash. D. C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/9/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>NOV 8 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Robert A. Pumphrey</b>		25c. DATE <b>NOV 8 '61</b>	



1  
FOR STATE  
HEALTH DEPT.

1. This certificate should be executed within 24 hours after death. If delay is necessary, it should be executed by a physician, a coroner, or a funeral director. Page 1, 2, and 3 should be retained for your files. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO REMOVE FROM FILE: This certificate should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. Its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 20 & 21-61 Film 301  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12754

1. PLACE OF DEATH  
a. COUNTY Montgomery MARYLAND  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda  
c. LENGTH OF STAY IN 1b  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8504 Rayburn Rd

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)  
a. STATE Md. b. COUNTY Montgomery  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 46 Bethesda  
d. STREET ADDRESS 8504 Rayburn Rd

3. NAME OF DECEASED (Type or print) Howard Raymond Campbell  
4. SEX Male 5. COLOR OR RACE White 6. MARRIED ☒ NEVER MARRIED ☐ 7. WIDOWED ☐ DIVORCED ☐  
8. AGE (In years, last birthday) 59 yrs. 9. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. November 8 19 61

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacist 10b. KIND OF BUSINESS OR INDUSTRY Retired 11. BIRTHPLACE (State or foreign country) Falls River, Mass. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Clarence C. Campbell 14. MOTHER'S MAIDEN NAME Margaret Stewart

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ? 16. SOCIAL SECURITY NO. ? 17. INFORMANT wife, Cornelia N. Campbell, Same #2 Address \_\_\_\_\_

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Contusion, severe, jaw & brain stem  
904.0 DUE TO (b) Blunt trauma  
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO \_\_\_\_\_  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) \_\_\_\_\_ 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Assumed that he fell in his room at home

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home 20f. (City or town) Montg. (County) Md. (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒

ACTUAL SIGNATURE Frank Brochart M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 11/8/61

EXAMINER'S NAME (Type) Frank Brochart Address (Street, city, town, or county) \_\_\_\_\_

22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 22b. DATE THEREOF 11/10/1961 22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory 22d. LOCATION (City, town, or country) New Bedford, Mass. (State) \_\_\_\_\_

23. FUNERAL DIRECTOR The S.H. Hines Co. - 2901 14th St., N.W. - Washington, D.C. 24a. REC'D BY REGISTRAR Arthur S. Hines 24b. REGISTRAR'S SIGNATURE \_\_\_\_\_ DATE NOV 10 '61



1956-6

1956-6

## 1275

Items #13 & #17 - 11m x 11m - 11/27/61-mnh

**MEDICAL CERTIFICATION**

VR A15 (4)  
ISM 7 61



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

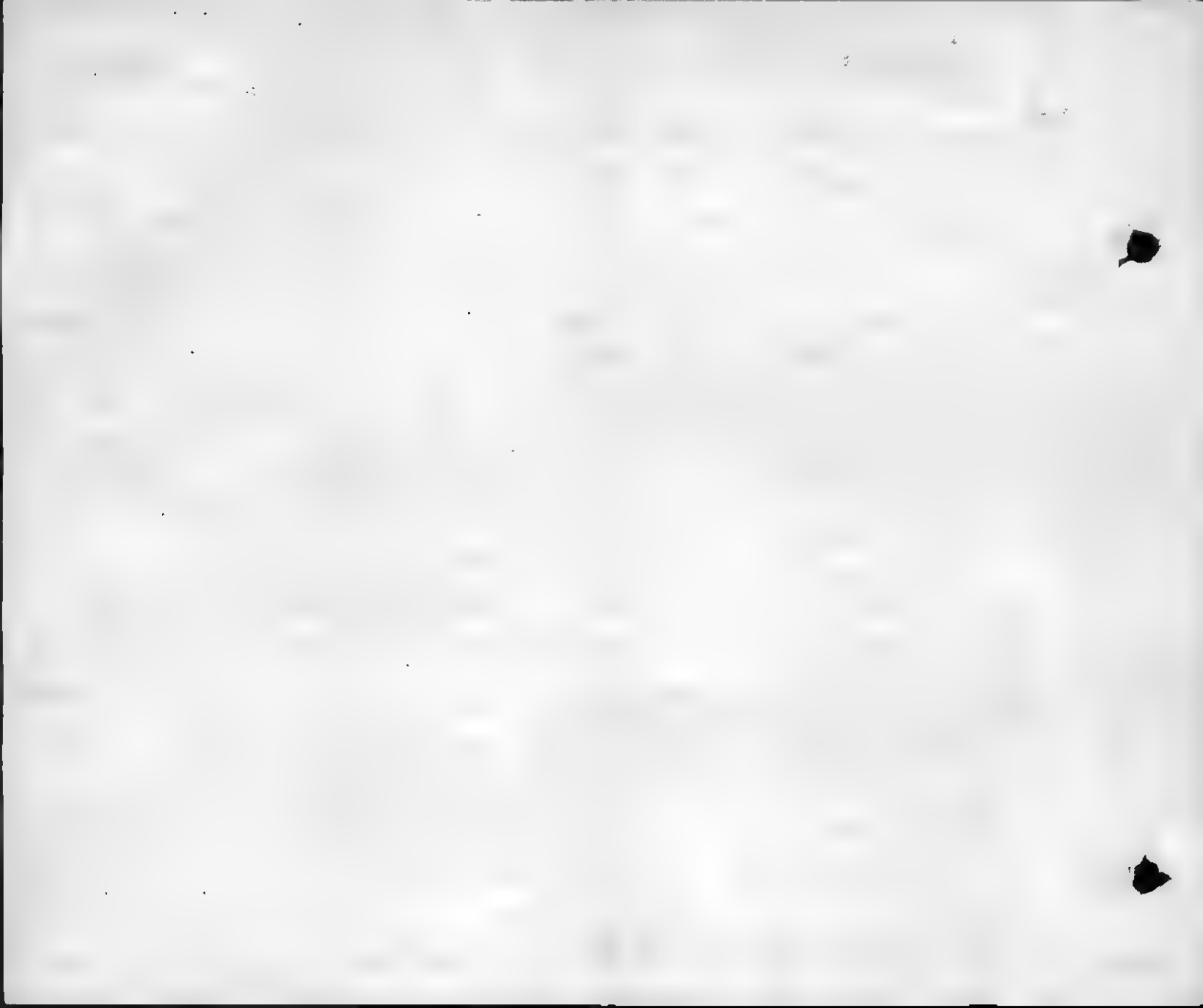
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12769

12756

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>5 mo</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>8600 16th St, apt 1010</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 24</u> d. STREET ADDRESS <u>8600 16th St, apt 1010</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Charles Edward Cannon</u>		<b>4. DATE OF DEATH</b> <u>nov 19 1961</u>		<b>9. AGE</b> (in years last birthday) <u>68</u> yrs. IF UNDER 1 YEAR: Months <u>11</u> Days <u>18</u> Hours <u>18</u> Min.			
<b>5. SEX</b> <u>male</u> <b>6. COLOR OR RACE</b> <u>white</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>11-18-1893</u>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, or as a retired) <u>Det. M. Police</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>retired</u>			
<b>11. BIRTHPLACE</b> (State or foreign country) <u>DC</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>Cannon</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service) <b>16. SOCIAL SECURITY NO.</b> <u>11-18-1893</u> <b>17. INFORMANT</b> <u>Mary A. Cannon (wife)</u> Address <u>Itum 2</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>420.1</u> (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a). <u>History of previous coronary disease</u>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a.m. <u>19</u> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broeschant</u> M.D. <b>EXAMINER'S NAME (Type)</b> <u>FRANK J. BROESCHANT</u>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>11-19-61</u>		<b>DATE SIGNED</b>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>22b. DATE THEREOF</b> <u>11-22-61</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt. Aleut</u> <b>22d. LOCATION (City, town, or country)</b> (State) <u>Washington DC</u>		<b>24a. REC'D BY REGISTRAR</b> <u>NOV 21 '61</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>E. J. Kline</u>					



## CERTIFICATE OF DEATH

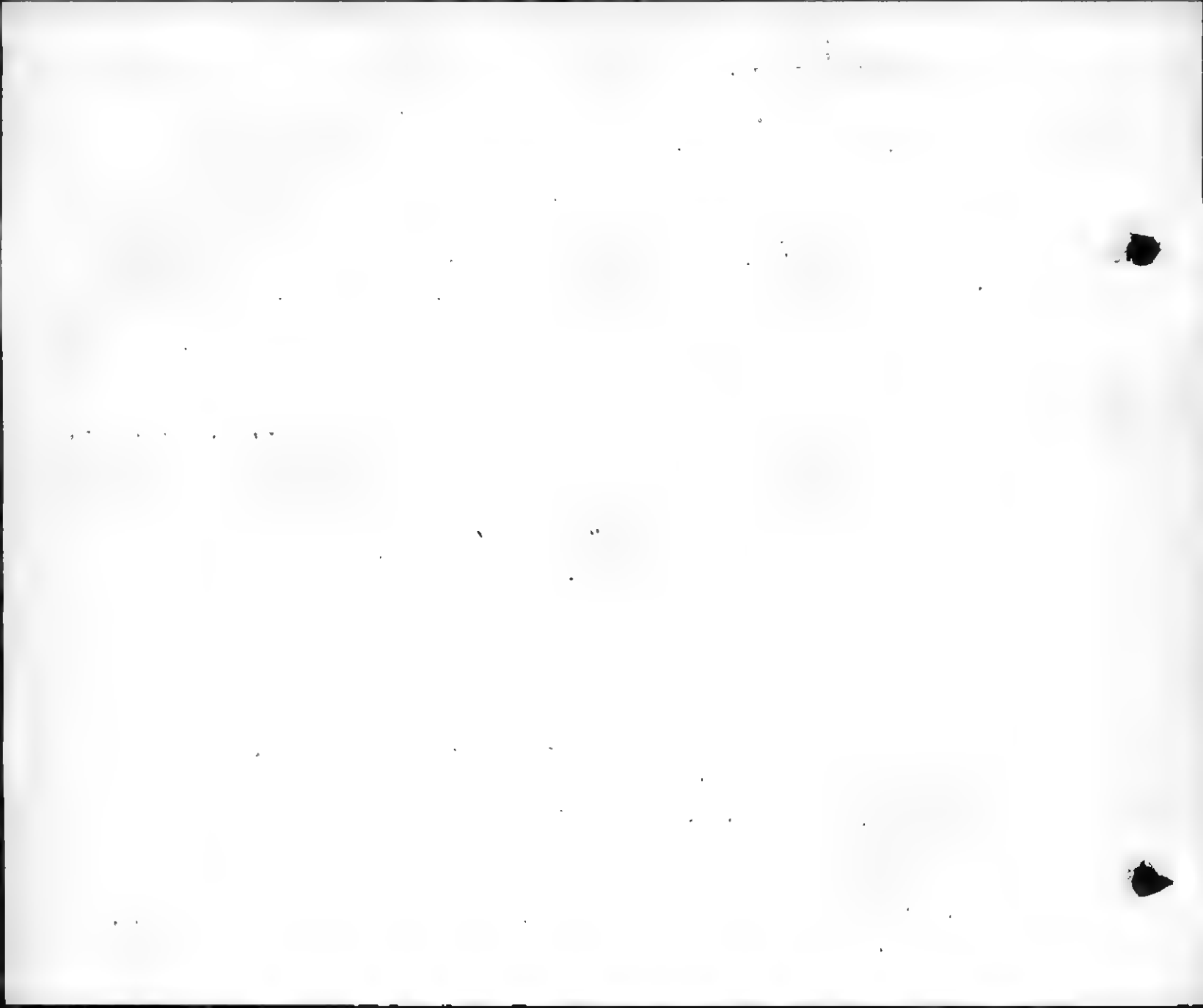
Reg. Dist. No. 12757

12770

1. PLACE OF DEATH o. COUNTY <u>Montg.</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germanstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Boyd Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Marylander Rest Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ASENATH</u> First Middle Last <u>CHADWICK</u>		4. DATE OF DEATH <u>Nov.</u> Month <u>29</u> Day <u>1961</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 10-1875</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u>18</u> Days <u>18</u>	IF UNDER 24 HRS Hours <u>18</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home work</u>	11. BIRTHPLACE (State or foreign country) <u>Alexandria.Va.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		13. FATHER'S NAME <u>Willard P. Graves</u>	
14. MOTHER'S MAIDEN NAME <u>Lucy Libby</u>		15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service: <input type="checkbox"/>	
16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>George A. Chadwick, Jr., Boyd, Md.</u>		17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral vascular accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) <u>Embolism</u> <u>arteriosclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>_____</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>10 days</u> <u>5 years</u>	
18a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		18b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>_____</u>	
19a. TIME OF INJURY Month. Day. Year Hour o. m. _____ p. m. _____ 19		19b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
19c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>_____</u>		19d. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Jan 28</u> 19 <u>49</u> , to <u>29 Nov, 1961</u> , that I last saw the deceased alive on <u>28 Nov, 1961</u> , and that death occurred at <u>3:00 PM</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE <u>John G. Fawcett</u> M.D. PHYSICIAN'S NAME (Type) <u>John G. Fawcett</u> <u>Dawsonsville</u> <u>Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-1-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Darnestown Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Darnestown Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Ernest G. Gartner, Gaithersburg, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 1 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles E. Kneel</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



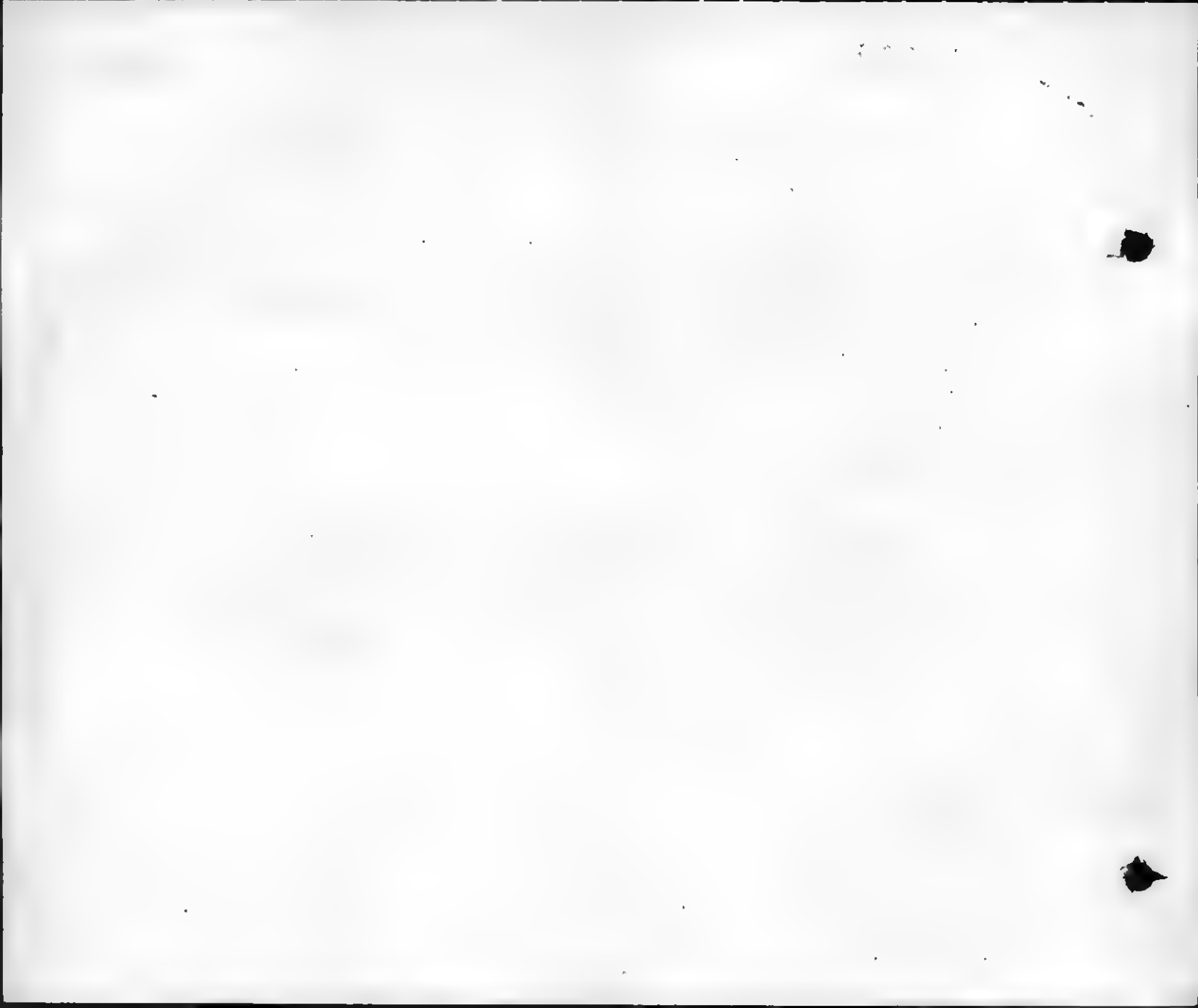
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)  
15M 9/59

1  
12771  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
12758

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>Mont.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>47 Bethesda.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Lila M. Chandler</i>				4. DATE OF DEATH Month Day Year <i>Nov. 11 1961</i>			
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 12, 1883</i>	9. AGE (in years last birthday) <i>78</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>talent ed manager. govt.</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Iowa</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		
13. FATHER'S NAME <i>August W. Nelson</i>			14. MOTHER'S MAIDEN NAME <i>Christine Johnson</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>			16. SOCIAL SECURITY NO. <i>no</i>		17. INFORMANT Name Address <i>Louise Clark / 1514 1st Ave.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Failure</i> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>arterosclerotic Heart Disease</i> DUE TO (c) <i>Diabetic Mellitus</i>							INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i> <i>10 years</i> <i>10 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>GI Bleeding - possible Carcinoma Stomach</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>11/61</i> to <i>11-11, 1961</i> , that (I) (we) last saw the deceased alive on <i>11/11</i> 19 <i>61</i> , and that death occurred at <i>4:30 PM</i> , from the causes and on the date stated above.							
22a. SIGNATURE <i>W H Kilian</i>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>W H KILIAN MD</i>			22d. ADDRESS <i>8218 Wisconsin Ave</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11/14/61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Glenwood Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Washington, D. C.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey, Bethesda, Maryland</i>				25a. REC'D BY REGISTRAR DATE <i>NOV 14 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

MEDICAL CERTIFICATION



by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

12772

12759

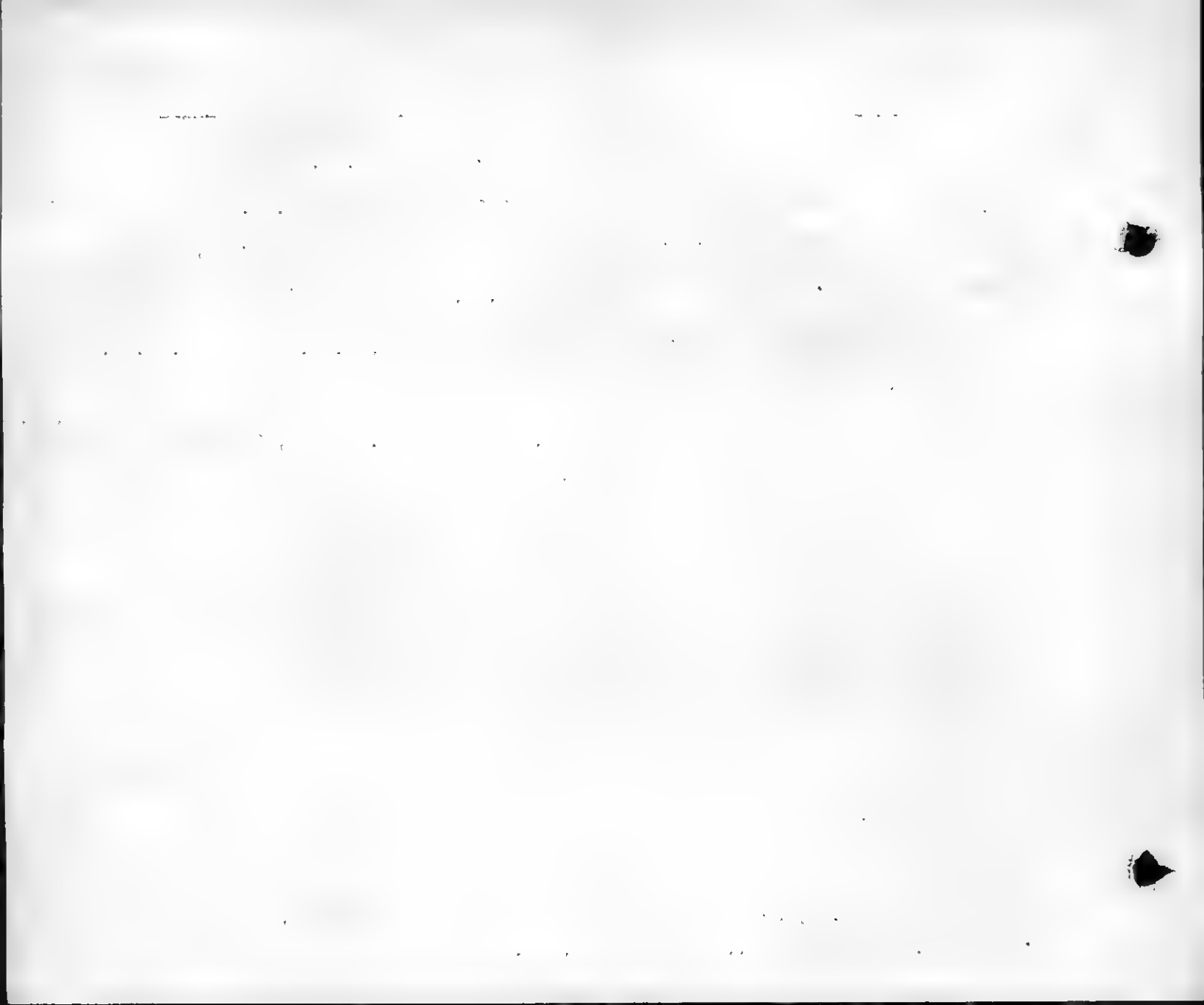
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON, D. C.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>				c. LENGTH OF STAY IN 1b <b>1 month</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>KENSINGTON GARDENS SANITARIUM</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HELEN LOUISE CHASE</b> Middle <b>LOUISE</b> Last <b>CHASE</b>				4. DATE OF DEATH Month <b>NOVEMBER 5,</b> Day <b>1961</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>NOV. 7, 1906</b>	
9. AGE (in years last birthday) <b>54</b> yrs		10. IF UNDER 1 YEAR Months <b>54</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		11. IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALES CLERK LANSBURGH</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>DEPARTMENT STORE</b>			
11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D. C.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>AMBROSE L. CHASE</b>				14. MOTHER'S MAIDEN NAME <b>JULIA MILLER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>578-54-9200</b>			
17. INFORMANT <b>MRS. MARGUERITE C. DUVALL</b>				Address <b>SILVER SPRING, MD. 9201 BLIGO CREEK PKWY.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA</b> DUE TO <b>CARCINOMA OF COLON</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <b>CARCINOMA OF COLON</b> DUE TO (c) <b>CARCINOMA OF COLON</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 YR. 18 MOS.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>11</b> p. m. <b>5</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>MAR 1961</b> to <b>NOV 5 1961</b> , that (I) (we) lost saw the deceased alive on <b>11/5 1961</b> , and that death occurred at <b>3:30 AM</b> , from the causes and on the date stated above							
22a. SIGNATURE <b>John H. Tuohy</b>				22b. DATE SIGNED <b>11/5/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>JOHN H. TUOHY, M.D.</b>				22d. ADDRESS <b>7720 WISCONSIN AVE BETHESDA 14, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>NOV. 8, 1961</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEMETERY</b>				23d. LOCATION (City, town, or county) (State) <b>SUITLAND, MARYLAND</b>			
24. FUNERAL DIRECTOR'S NAME (Type) <b>WARNER E. PUMPHREY, INC., SILVER SPRING, MD.</b>				25a. REC'D BY REGISTRAR <b>NOV 7 '61</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>				25c. REGISTRAR'S NAME <b>Arthur S. House</b>			

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The law requires that the death certificate be filled in by the funeral director, page 4 may be retained by the hospital or attending physician and completed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

12773

12760

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> c. LENGTH OF STAY IN Tb d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>BEL PRE NURSING HOME</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>5437 - Conn. Ave. N.W. 47X3</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>LORETTA</u> First Middle Last <b>5. SEX</b> <u>FEM.</u> <b>6. COLOR OR RACE</b> <u>WHITE</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>July 30, 1891</u> <b>9. AGE</b> (In years last birthday) <u>70</u> yrs. <b>10. IF UNDER 1 YEAR</b> Months Days <b>11. IF UNDER 24 HRS.</b> Hours Min.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>House-wife</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>At Home</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Mass.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Riley S. Barber</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Aedia B. Acherty</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>None</u> <b>17. INFORMANT</b> <u>Mae L. Wagner</u> Address <u>Some 25 #2</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> 322X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerosis and diabetes</u> (c) DUE TO		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):</b>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>June 19, 1960</u> <b>to</b> <u>Nov. 15, 1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>Nov. 15, 1961</u> , <b>and that death occurred at</b> <u>M</u> , <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Jerome J. Krick</u> <b>22b. DATE SIGNED</b>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Jerome J. Krick</u> <b>22d. ADDRESS</b> <u>2800 QUEBEC ST. N.W. WASH. D.C.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>23b. DATE THEREOF</b> <u>Nov. 18, 1961</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Rock Creek</u> <b>23d. LOCATION (City, town or county) (State)</b> <u>Wash. D.C.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>W.W. Chambers</u> <b>25. REC'D BY REGISTRAR</b> <u>Nov 21 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Conrad L. Kraus</u>	

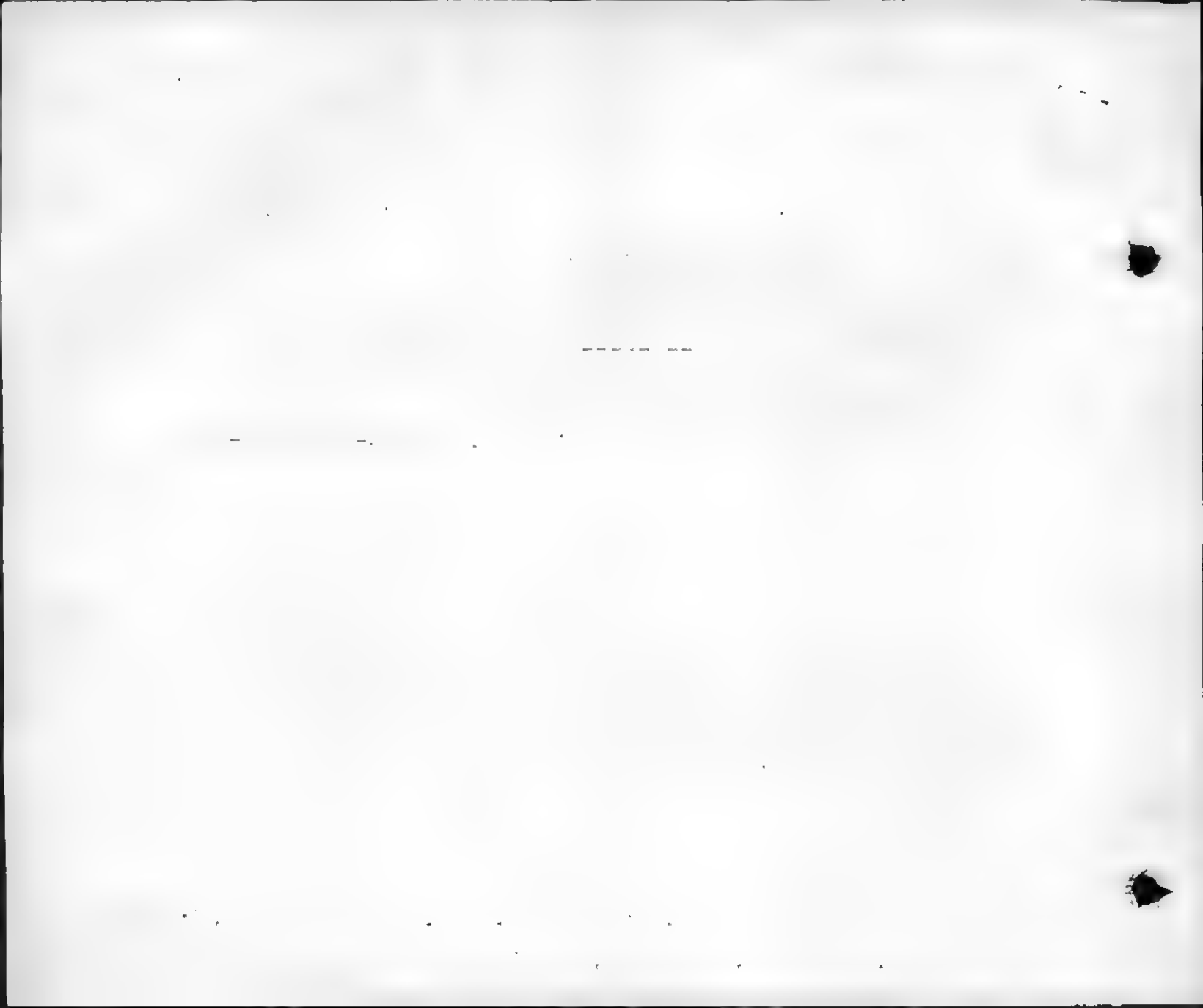


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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
must be retained by the hospital or attending physician  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admittance) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>LeDeau Gardens</b>		d. STREET ADDRESS <b>10705 Maybrook Place</b>	
3. NAME OF DECEASED (Type or print) <b>Mary Elizabeth CHAGGETT</b>		4. DATE OF DEATH <b>Nov 4 1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/4/1870</b>
9. AGE (In years last birthday) <b>91</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Benjamin White</b>		14. MOTHER'S MAIDEN NAME <b>(Unknown) Viers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>Mary M. Cuttle-daughter-same 2d</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-pneumonia</b> 10:0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Thrombosis</b> DUE TO (c) <b>Pernicious Anemia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>48 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sep 1961</b> to <b>Nov 4 1961</b> that (I) (we) last saw the deceased alive on <b>Nov 3 1961</b> and that death occurred at <b>4:30 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert T. Threadgill</b> M.D.		22b. DATE SIGNED <b>Nov 4 61</b>	
22c. PHYSICIAN'S NAME (Type) <b>ROBERT T. THREADGILL</b>		22d. ADDRESS <b>10609 CANON ST. KENS. MD</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/6/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Marks Epis. Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Petersville, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 8 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12775

12762

### PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Beltsville Takoma Park

c. LENGTH OF STAY IN 1b

2 DAYS

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Washington Sanitarium & Hospital

3. NAME OF DECEASED (Type or print)

Frank

Arnold

5. SEX

male

6. COLOR OR RACE

white

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

3-7-84

9. AGE (In years last birthday)

77 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired - Book Editor

10b. KIND OF BUSINESS OR INDUSTRY

PUBLISHING

11. BIRTHPLACE (County & State or foreign country)

Massachusetts

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George Coffin

14. MOTHER'S MAIDEN NAME

Emma Packard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

NO

16. SOCIAL SECURITY NO

17. INFORMANT

Old Record - Wife - same address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)

163X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

(c)

Cancer of Lung due to cancer of Ca. Thrombosis cerebral thrombosis

INTERVAL BETWEEN ONSET AND DEATH

1-2 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Double heavy iron melatonin

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I. of item 18)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from AUGUST 1961 to NOV 21 1961, that (I) (we) last saw the deceased alive on NOV 21 1961, and that death occurred at 3:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE

Chas H. Wilkerson

M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22b. DATE SIGNED

11-21-61

22c. PHYSICIAN'S NAME (Type)

Chas H. Wilkerson

22d. ADDRESS

7607 Carroll Ave Takoma Park Md.

23a. BURIAL, CREMATION, or other disposal (Specify)

Burial

23b. DATE THEREOF

Nov. 22-1961

23c. NAME OF CEMETERY OR CREMATORY

George Washington

23d. LOCATION (City, town or county)

Hyattsville Prince Georges Md.

24. FUNERAL DIRECTOR'S SIGNATURE

Arthur Walters

25a. REC'D BY REGISTRAR

254 Carroll Ave. N.E. 7-31

25b. REGISTRAR'S SIGNATURE

NOV 24 '61

25c. REGISTRAR'S SIGNATURE

Arthur S. Frank



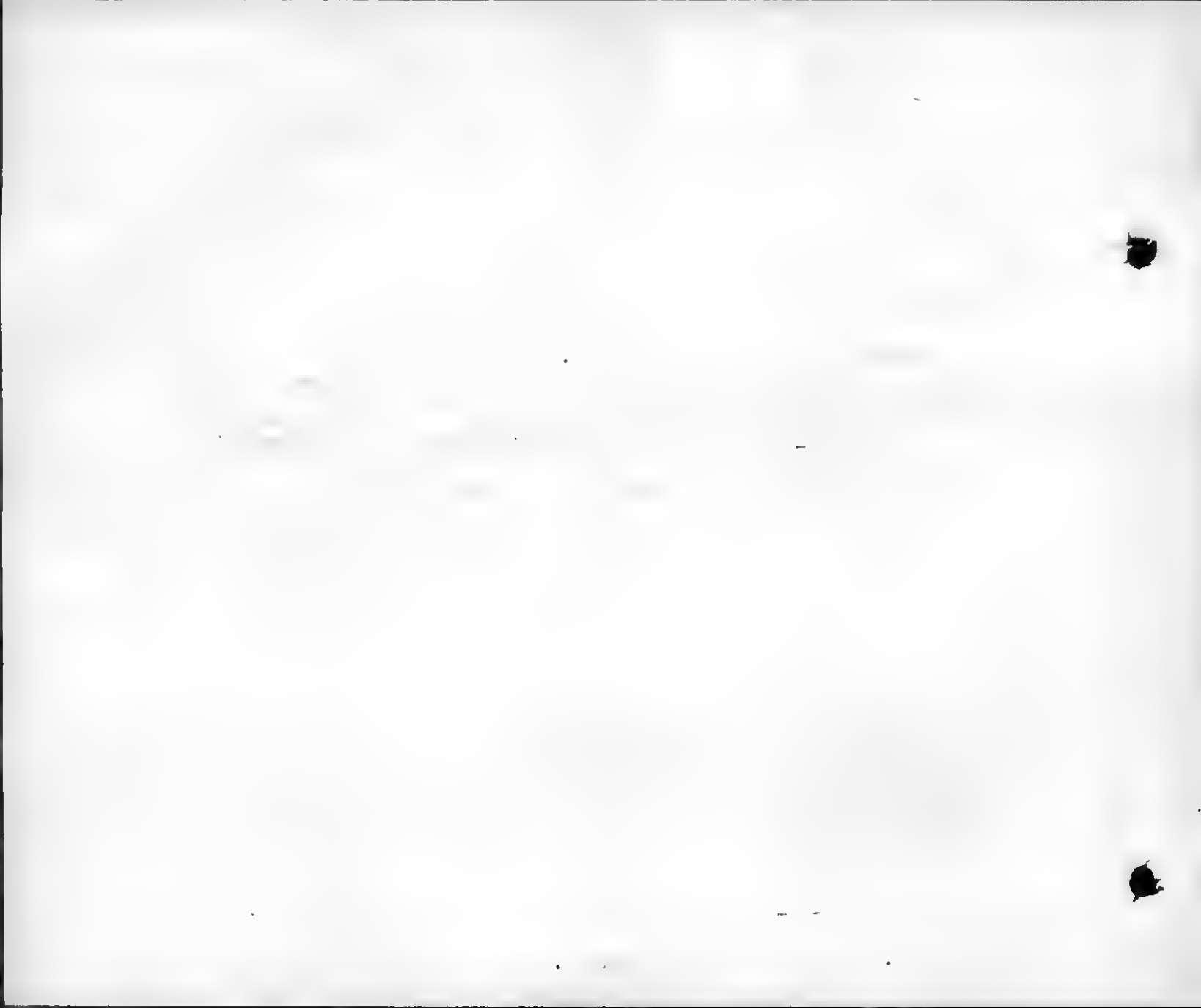
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

12776

12763

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Florida</i> b. COUNTY <i>Dade</i> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Olney</i>		c. LENGTH OF STAY IN 1b <i>1 yr 11 mo</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Brooke Grove Foundation</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Miami</i>	
f. STREET ADDRESS <i>9443 SW 36th St</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Jennie June Colburn</i>		4. DATE OF DEATH Month Day Year <i>Nov 10 1961</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>Cauc</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 28 1869</i>
9. AGE (in years last birthday) <i>92</i> yrs	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>dressmaker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>self emp.</i>	
11. BIRTHPLACE (State or foreign country) <i>Wisconsin</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Washburn Cleveland</i>		14. MOTHER'S MAIDEN NAME <i>Anne Butterfield</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO <i>none</i>	
17. INFORMANT Address <i>Catherine Atwood</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>332x Sepsis thrombotic</i> DUE TO (b) <i>Generalized arteriosclerosis</i> DUE TO (c) <i>lying cause lost.</i>			INTERVAL BETWEEN ONSET AND DEATH <i>3 yr</i> <i>20 yr</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Jan 1941</i> , to <i>Nov 1961</i> , that (I) (we) last saw the deceased alive on <i>Nov 1 1961</i> , and that death occurred at <i>9:30 AM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>A. D. Brizant</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>A. D. BENIFANT</i>		22d. ADDRESS <i>Sandy Spring, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE THEREOF <i>11-11-61</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Lake Mill</i>	23d. LOCATION (City, town, or county) (State) <i>Lake Mills, Wisconsin</i>
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Francis H. Barber Laytonsville, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>NOV 15 '61</i>	25b. REGISTRAR'S SIGNATURE <i>William S. Kane</i>



FOR STATE  
HEALTH DEPT.

TO DEDUCT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Regs 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

Items 18 & 21 Film 301  
11-71-61 ams

**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 12777 12764

1. PLACE OF DEATH  
a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ulnsey c. LENGTH OF STAY IN 1b Do.A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Montgomery General Hosp

2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)  
a. STATE md b. COUNTY Montg c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ulnsey d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) Elgar Copeland 4. DATE OF DEATH Nov 6 1961 5. SEX male 6. COLOR OR RACE col 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH April 13, 1901 9. AGE (in years last birthday) 60 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) labourer 10b. KIND OF BUSINESS OR INDUSTRY md 11. BIRTHPLACE (State or country) md 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME James Copeland 14. MOTHER'S MAIDEN NAME Martha

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. 11-7-61 17. INFORMANT Albert Murphy - Ulnsey, md Address Ulnsey, md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Myocarditis, moderately severe  
343X DUE TO  
Conditions, if any, which gave rise to immediate cause (b) Encephalitis, mild  
(a), stating the underlying cause last. DUE TO  
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH ?

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While ☐ at work ☐ Not While ☐ at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

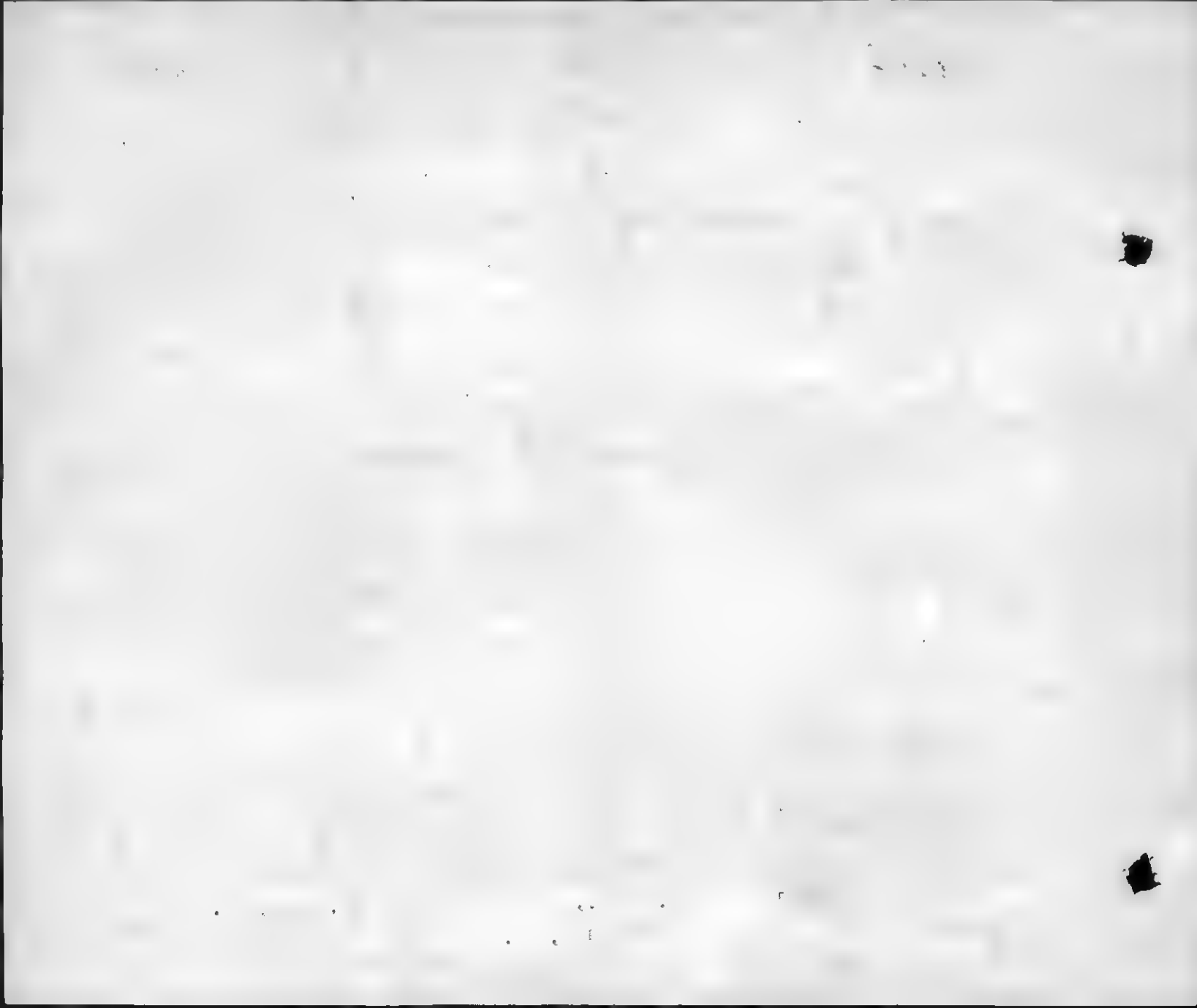
21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 11-7-61

ACTUAL SIGNATURE Frank J. Broschart EXAMINER'S NAME (Type) FRANK J. Broschart Address (Street, city, town, or county) Rockville, Md.

22a. BURIAL, CREMATION, REBURY (city) Burial 22b. DATE THEREOF 11/12/61 22c. NAME OF CEMETERY OR CREMATORY Mt. Zion. 22d. LOCATION (City, town, or county) (State) Mt. Zion, Md.

23. FUNERAL DIRECTOR Robert P. Snowden ADDRESS Rockville, Md. 24a. REC'D BY REGISTRAR NOV 15 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Thomas



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

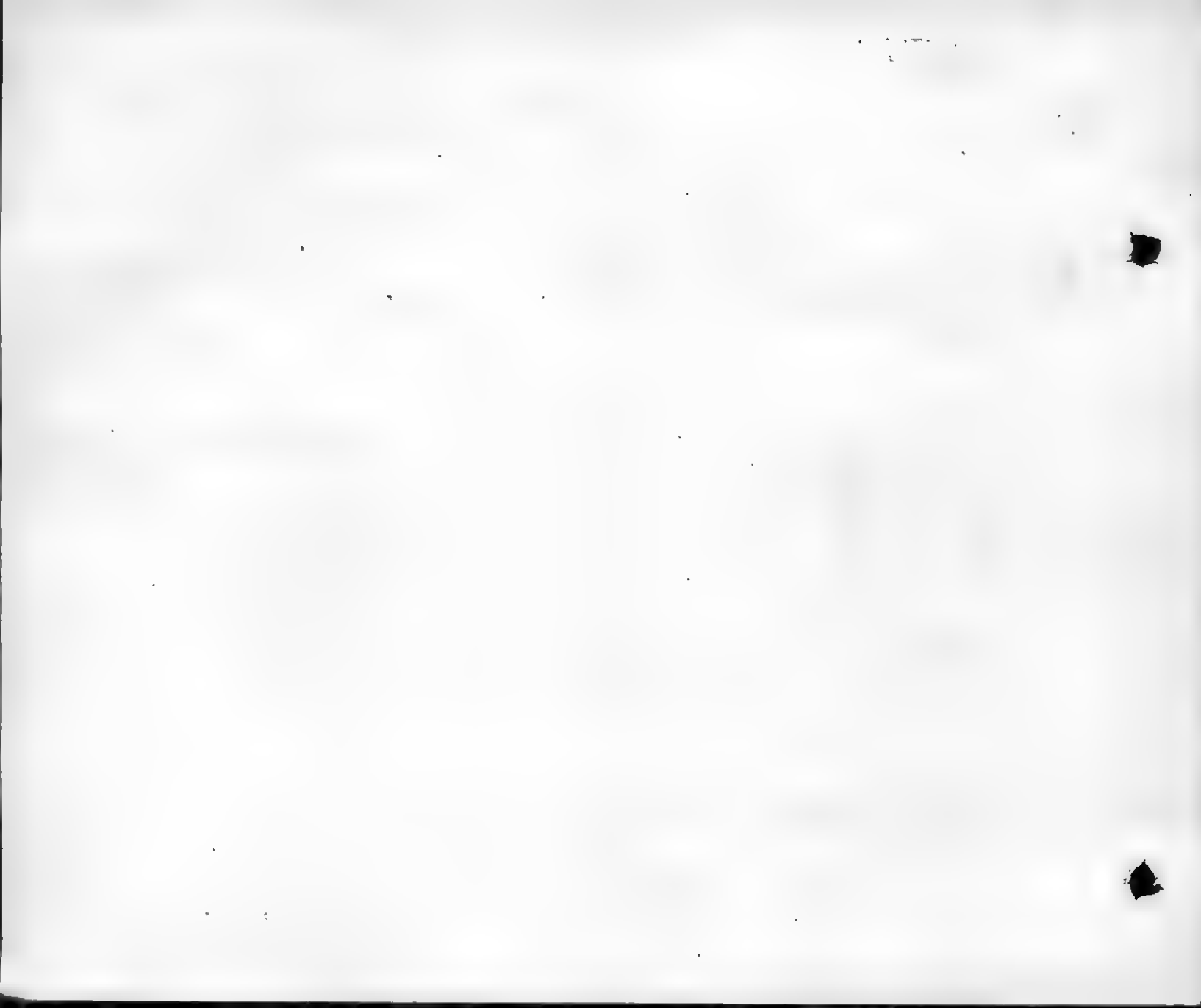
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12761

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>				c. LENGTH OF STAY IN 1b <b>16 Months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Kensington Gardens Sanitarium</b>				e. STREET ADDRESS <b>9901 Connecticut Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>ELLA</b> Middle <b>IRVIN</b> Last <b>COWARD</b>				4. DATE OF DEATH Month <b>November</b> Day <b>2</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 27, 1880</b>	
9. AGE (In years last birthday) <b>81 yrs</b>		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>4</b> Hours <b>1</b> Min <b>1</b>		11. IF UNDER 24 HRS. Months <b>6</b> Days <b>4</b> Hours <b>1</b> Min <b>1</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>	
13. FATHER'S NAME <b>Horace Irvin</b>				14. MOTHER'S MAIDEN NAME <b>Ella Jewel</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Medical Record Kensington Gard, Sanitarium</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> DUE TO <b>Arteriosclerosis of Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Severity (79 yr age)</b> (b) <b>Arteriosclerosis of Heart Disease</b> DUE TO <b>Severity (79 yr age)</b> (c) <b>Arteriosclerosis of Heart Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1 yr.</b> <b>6 yrs.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b> <b>6 yrs.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 1958</b> to <b>2 Nov. 1961</b> , that (I) <del>was</del> last saw the deceased alive on <b>10-15-1961</b> , and that death occurred at <b>7:45 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Samuel T. Hendell</b> M.D.				22b. DATE SIGNED <b>2 Nov. '61</b>			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <b>927 Parkside Drive Silver Spring, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>11-4-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION (City, town, or county) (State) <b>Suitland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Gawler's Sons, Inc. 1736-Pa. Ave. NW</b>				25a. REC'D BY REGISTRAR <b>NOV 6 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

**M**

**I**



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

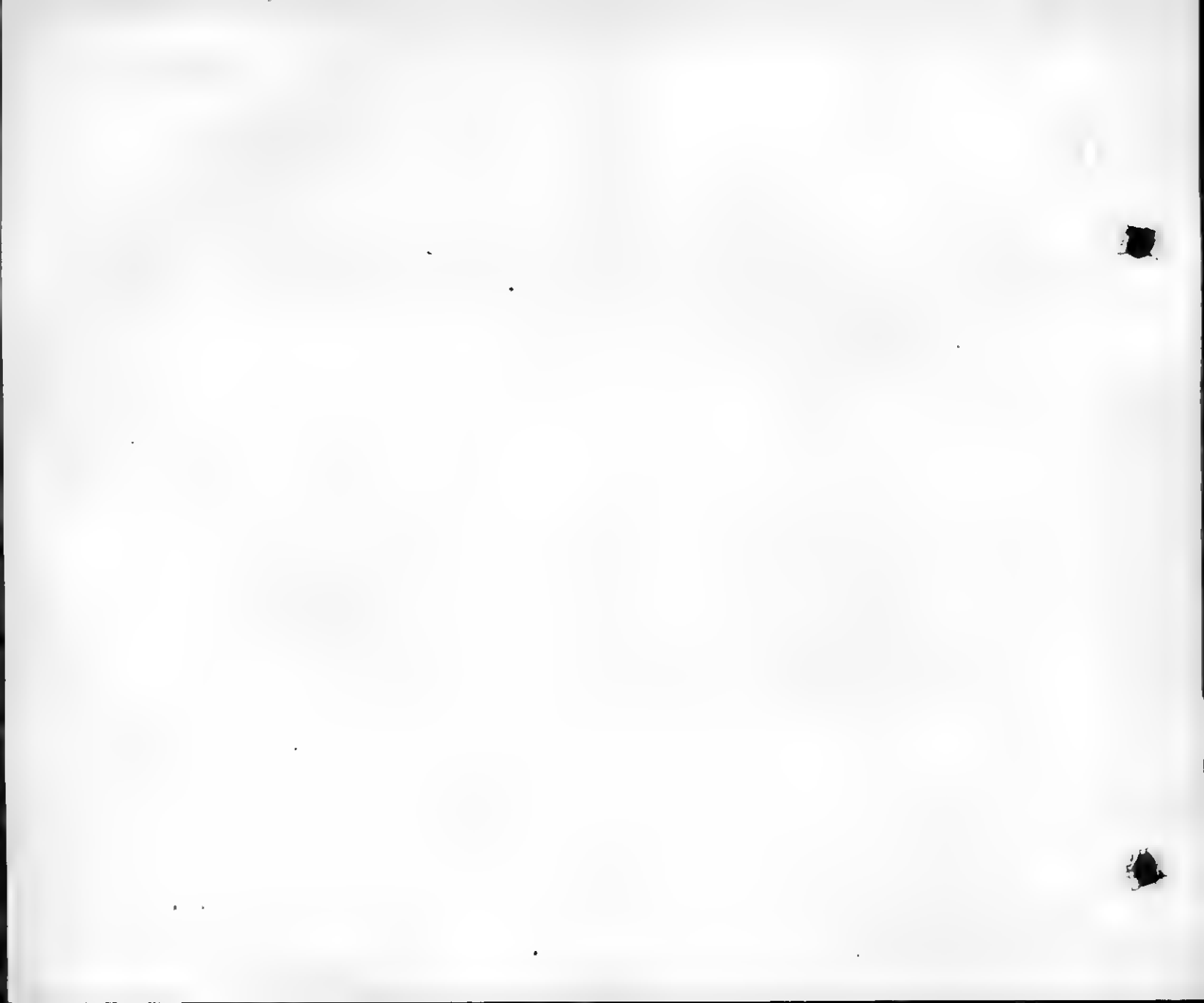
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
c. LENGTH OF STAY IN lb <u>4 mo</u>				d. STREET ADDRESS <u>1290 Crittenden St. N.W.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Altavista Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>Crawford</u> Last <u>Crawford</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>30</u> Year <u>1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 8, 1873</u>	
9. AGE (In years last birthday) <u>88</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Dept Store</u>		11. BIRTHPLACE (State or foreign country) <u>Nebraska</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S</u>							
13. FATHER'S NAME <u>James C. Crawford</u>				14. MOTHER'S MAIDEN NAME <u>Kate Moore</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Mr. Edwin C. Blanchard</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (b) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH <u>7 YEARS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>61</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>							
21. I certify that (I) (this hospital) attended the deceased from <u>June 1961</u> to <u>Nov. 30, 1961</u> , that (I) <u>was</u> last saw the deceased alive on <u>Nov 29, 1961</u> , and that death occurred at <u>5 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Delwitt E. DeLAWTER</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/30/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>DeWITTE E. DeLAWTER</u>				22d. ADDRESS <u>8025 ARLINGDALE RD. Bethesda 14 Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>12/4/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Henry Co.</u>				25a. REC'D BY REGISTRAR <u>2801 9th St. N.W.</u> DATE <u>DEC 4 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Henry</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

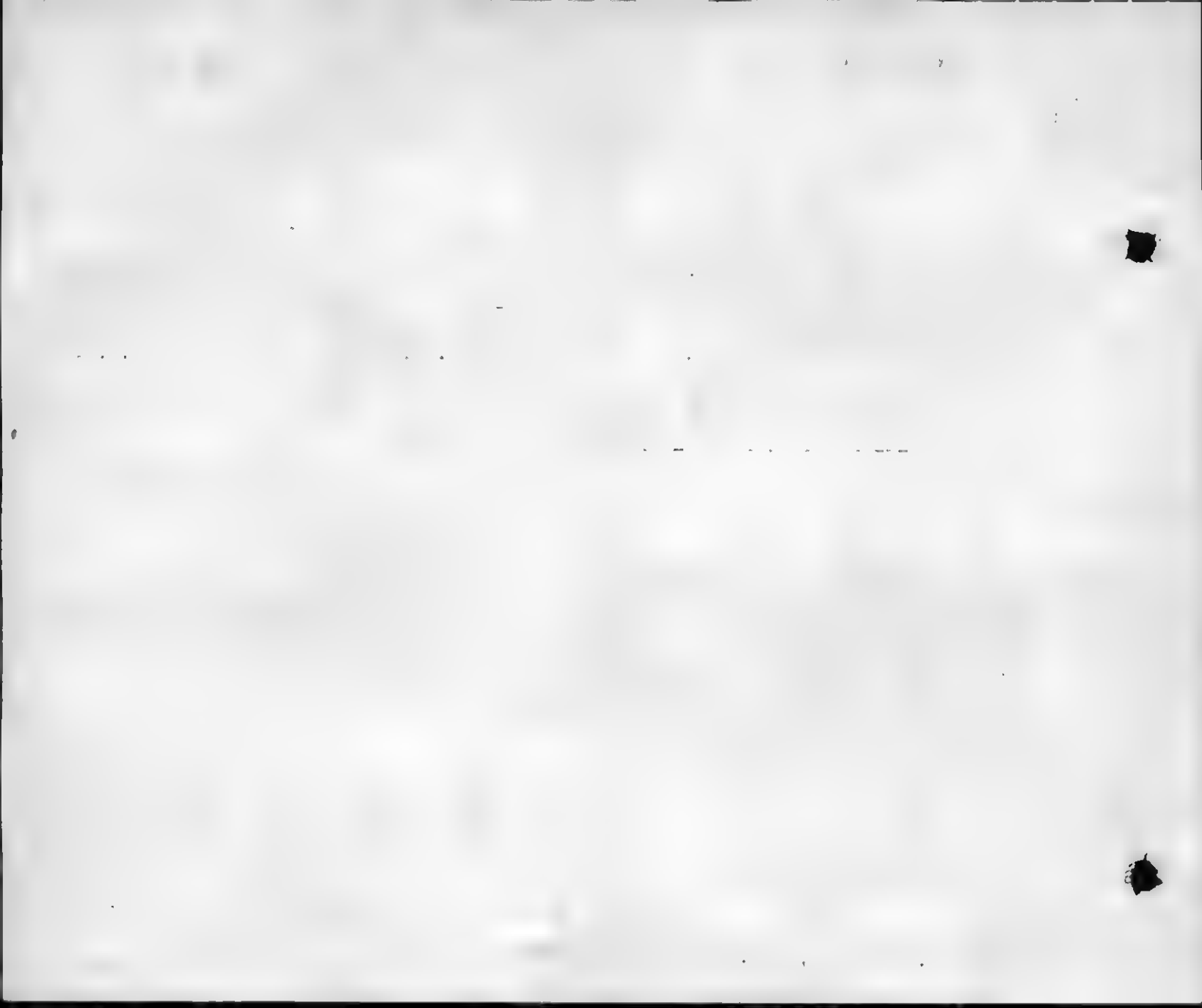
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## CERTIFICATE OF DEATH

12767

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN IL <u>11 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SUBURBAN</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> d. STREET ADDRESS <u>10408 MONTROSE AVE.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
<b>3. NAME OF DECEASED</b> (Type or print) <u>RALPH</u> <u>Whitney</u> <u>CREEL</u> First Middle Last		<b>4. DATE OF DEATH</b> <u>NOV. 23</u> <u>1961</u> Month Day Year		<b>5. SEX</b> <u>MALE</u>		<b>6. COLOR OR RACE</b> <u>WHITE</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>4-21-05</u>		<b>9. AGE</b> (In years last birthday) <u>56</u> yrs. <u>23</u> MONTHS <u>23</u> DAYS <u>15</u> HOURS <u>15</u> MIN.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired Policeman</u>		<b>11. BIRTHPLACE</b> (Country & State, or foreign country) <u>Wash. D.C.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>CLARENCE CREEL</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>ANNA H. SWART</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>579-50-3964</u>		<b>17. INFORMANT</b> <u>WIFE ELIXABETH SAME AS ABOVE</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>confluent bronchopneumonia</u> (b) <u>Cerebral INFARCTION</u> (c) <u>Arteriosclerosis, generalized</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>					
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>11/23, 1961</u> to <u>11/23, 1961</u> , that (I) (we) last saw the deceased alive on <u>11/23, 1961</u> , and that death occurred <u>2:30 P.M.</u> from the causes and on the date stated above.																			
<b>22a. SIGNATURE</b> <u>John B. Uthman</u>		<b>22b. DATE SIGNED</b> <u>Nov. 24/61</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>JOHN UTHMAN</u>		<b>22d. ADDRESS</b> <u>8805 Conn Ave Ch. Ch. 15 Md</u>		<b>22e. REC'D BY REGISTRAR</b> <u>NOV 27 '61</u>		<b>22f. REGISTRAR'S SIGNATURE</b> <u>Charles S. Frank</u>									
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>11/27/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Darnestown Presbyterian</u>		<b>23d. LOCATION</b> (City, town or county) <u>Montgomery</u>		<b>(State)</b> <u>Maryland</u>											
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Raymond H. Ziska</u> <u>8434 GEORGIA AVENUE</u> <b>24b. ADDRESS</b> <u>WARNER E. PIMPHREY, INC. SILVER SPRING, MARYLAND</u>																			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

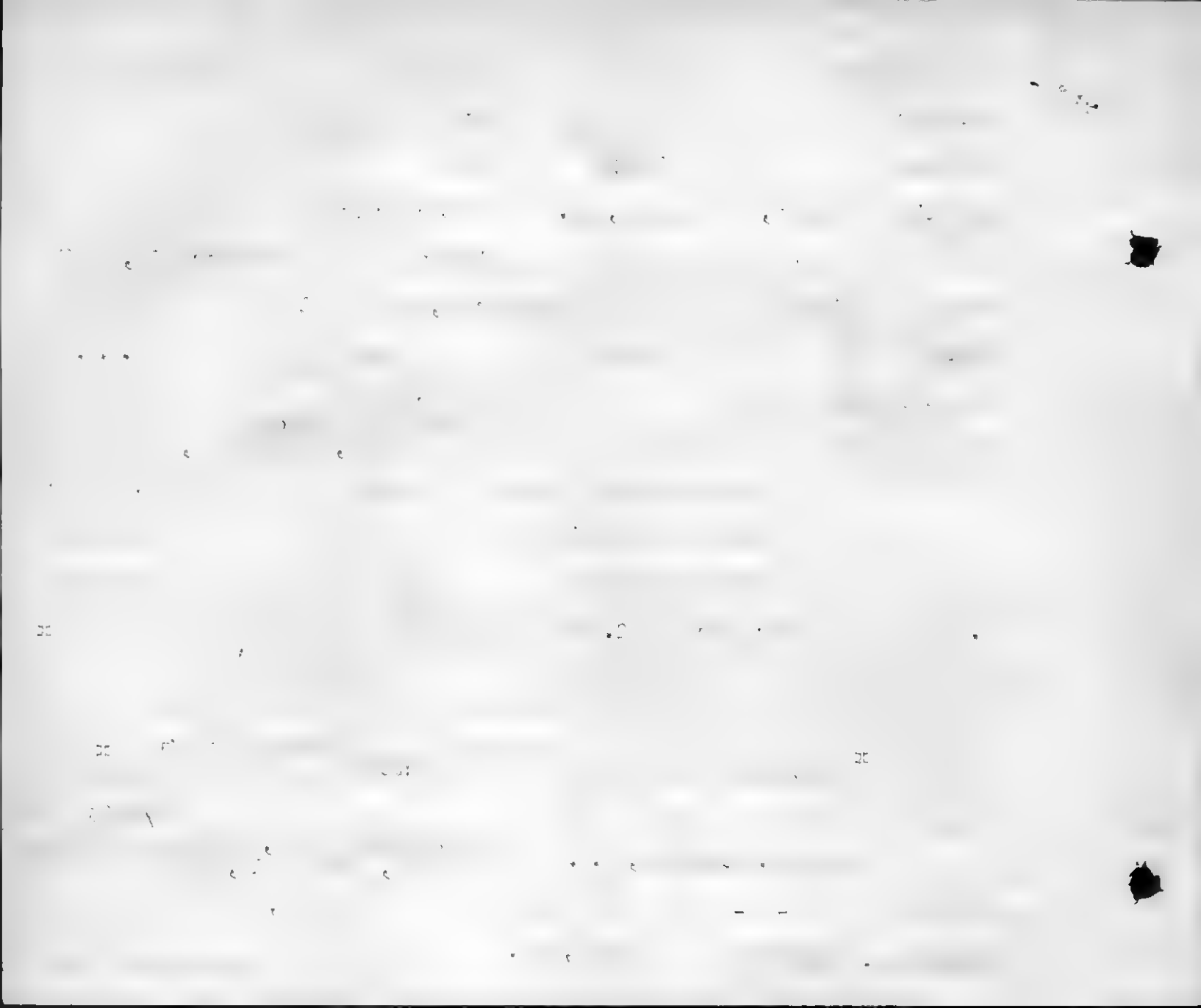
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12781

12768

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN b <b>5 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Iowa</b> b. COUNTY <b>Exira</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>No street address</b> d. STREET ADDRESS <b>No street address</b>	
3. NAME OF DECEASED (Type or print) <b>Cecil Kenneth Cullings</b>		4. DATE OF DEATH <b>November 11, 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 2, 1900</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Banker</b>		9. AGE (In years last birthday) <b>61</b> yrs.	
10b. KIND OF BUSINESS OR INDUSTRY <b>Banking</b>		11. BIRTHPLACE (Country & State, or foreign country) <b>Iowa</b>	
13. FATHER'S NAME <b>Phil Cullings</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		14. MOTHER'S MAIDEN NAME <b>Ida Parshall</b>	
16. SOCIAL SECURITY NO <b>WW 1</b>		17. INFORMANT <b>The Medical Record</b>	
18. CAUSE OF DEATH (Enter on 1 one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probable acute myocardial infarction</b> DUE TO (b) <b>Coronary Heart disease</b> DUE TO (c) <b>Diabetes Mellitus</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last, <b>260X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 1/2 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1. polycythemia rubra vera 2. Multiple myeloma</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year <b>November 11, 1961</b> Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Exira, Iowa</b>	
21. I certify that <b>1</b> (this hospital) attended the deceased from <b>November 11, 1961</b> , that <b>1</b> (we) last saw the deceased alive on <b>November 11, 1961</b> , and that death occurred at <b>6:20AM</b> from the causes and on the date stated above.		22a. SIGNATURE <b>Edward S. Henderson, M.D.</b>	
22b. PHYSICIAN'S NAME (Type) <b>Edward S. Henderson, M.D.</b>		22c. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit 11-12-61</b>		23b. DATE THEREOF <b>11-12-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Exira Cemetery</b>		23d. LOCATION (City, town or county) <b>Exira, Iowa</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>		25a. REC'D BY REGISTRAR <b>NOV 17 '61</b>	
ADDRESS <b>Bethesda, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	



## CERTIFICATE OF DEATH

Reg. D.H. No. C

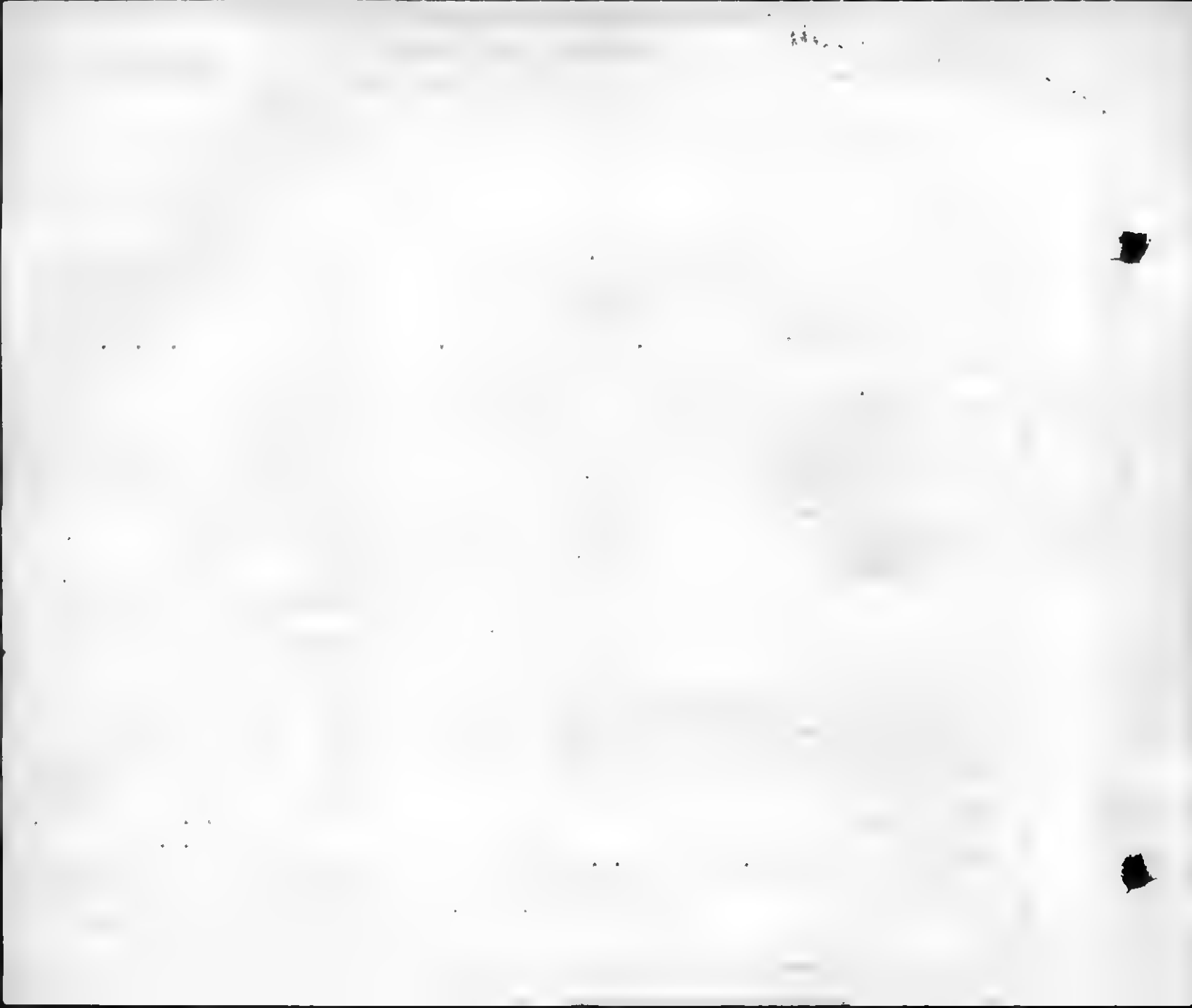
12782

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>5 Chevy Chase, Maryland.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>		d. STREET ADDRESS <b>13206 Rolling Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Richard</b> Middle <b>W.</b> Last <b>Cushing</b>		4. DATE OF DEATH Month <b>November</b> Day <b>17</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/9/84</b>
9. AGE (In years lost birthday) yrs. <b>77</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrical engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Govt.</b>	
11. BIRTHPLACE (State or foreign country) <b>Mass.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Louis T. Cushing</b>		14. MOTHER'S MAIDEN NAME <b>Mary Rebecca Fabens</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>yes World War I</b>		16. SOCIAL SECURITY NO. <b>No</b>	
17. INFORMANT <b>George Butler Cushing/same as above</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute cardiac failure</b> <b>177X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Bronchial and pulmonary carcinogenic metastasis</b> DUE TO <b>Prostatic carcinoma - left ureteral obstruction and left hydronephrosis</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus - 10 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b> <b>2 mos.</b> <b>1 year</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1951</b> , 19____, to <b>Nov. 17, 1961</b> , that I last saw the deceased alive on <b>November 17, 1961</b> , and that death occurred at <b>10:00 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3805 McKinley St., N.W., Washington, D.C. (15)</b> DATE SIGNED			
ACTUAL SIGNATURE <b>Edward A. Krause</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Edward A. Krause, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/21/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat. Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>NOV 22 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles E. Krause</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12783

## CERTIFICATE OF DEATH

Reg. Dist. No. 2270

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> c. LENGTH OF STAY IN 1b - -		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Washington, D. C.</b> b. COUNTY <b>Washington, D. C.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D. C.</b> d. STREET ADDRESS <b>4108 Ingomar St., N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Elizabeth H. Davidson</b>		4. DATE OF DEATH Month Day Year <b>11 13 19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-2-1879</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY - - -	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry S. Houghton</b>		14. MOTHER'S MAIDEN NAME <b>Alice V. Ballentine</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) - - -		16. SOCIAL SECURITY NO. - - -	
17. INFORMANT <b>Woodson Houghton</b>		Address <b>Wash. D. C. 2337 Calif. St. N.W.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction, massive</b> 4-1-1 DUE TO (b) <b>Arteriosclerosis, advanced</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Hypertension, severe</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b> <b>10 yrst</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus, moderate 10 yrst</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11-13-1957</b> to <b>Nov 13, 1961</b> , that I last saw the deceased alive on <b>Nov 13, 1961</b> , and that death occurred at <b>932 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4740 Chevy Chase Dr. Wash. D.C.</b> DATE SIGNED <b>11/13/61</b> SIGNATURE <b>Stewart Clapp</b> M.D. PHYSICIAN'S NAME (Type) <b>Stewart Clapp</b> <b>Chevy Chase 15 Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-15-1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph G. ...</b>		24a. REC'D BY REGISTRAR <b>DATE NOV 16 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>...</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12784

## CERTIFICATE OF DEATH

12771

### 1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Suburban

3. NAME OF DECEASED (Type or print)

Agnes

First

Middle

L.

5. SEX

Female

White

6. COLOR OR RACE

WIDOWED

DIVORCED

7. MARRIED ☐ NEVER MARRIED ☐

8. DATE OF BIRTH

Aug; 28, 1885

9. AGE (in years last birthday)

76 yrs.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

13. FATHER'S NAME

Osala Salyards

14. MOTHER'S MAIDEN NAME

Virginia

U.S.A.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Daughter Virginia Blundon (Same as above)

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)

Cerebrovascular Thrombosis

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

Generalized arteriosclerosis

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

INTERVAL BETWEEN ONSET AND DEATH

4 days

15 days

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.

19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 11-7-61, 19 to 11-29, 1961, that (I) saw the deceased alive on 11-29-61, 19 and that death occurred at 11:00 AM, from the causes and on the date stated above.

22a. SIGNATURE

Dr. Morris Perry

M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22b. DATE SIGNED

11-29-61

22c. PHYSICIAN'S NAME (Type)

Dr. Morris Perry

22d. ADDRESS

11602 Georgia Ave. Silver Spring Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

12/2/61

23c. NAME OF CEMETERY OR CREMATORY

St. Matthews Luth. Cem.

23d. LOCATION (City, town or county)

New Market, Va.

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

300-4th NE Wash DC

25a. REC'D BY REGISTRAR

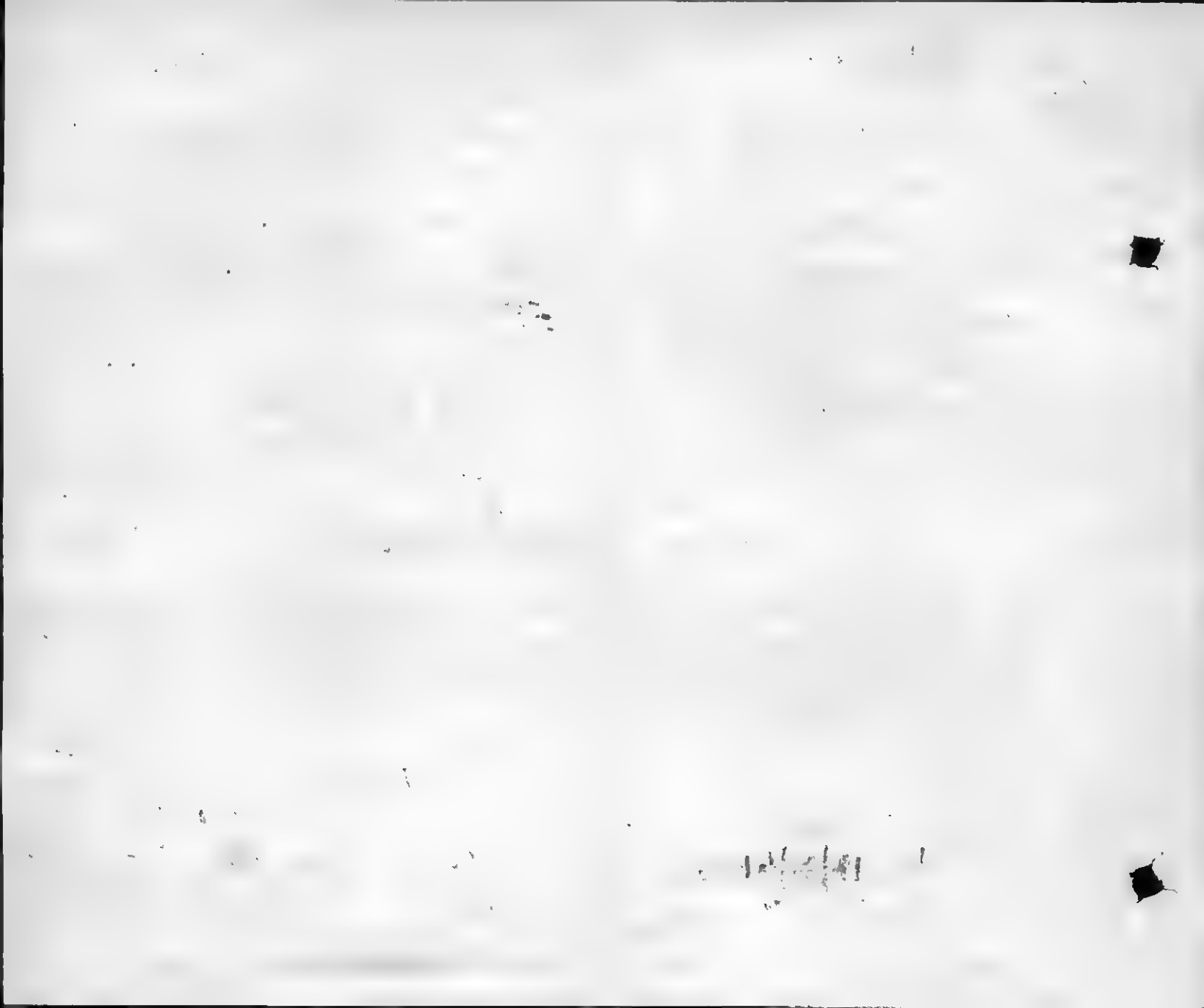
DEC 1 '61

25b. REGISTRAR'S SIGNATURE

Carlton S. H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



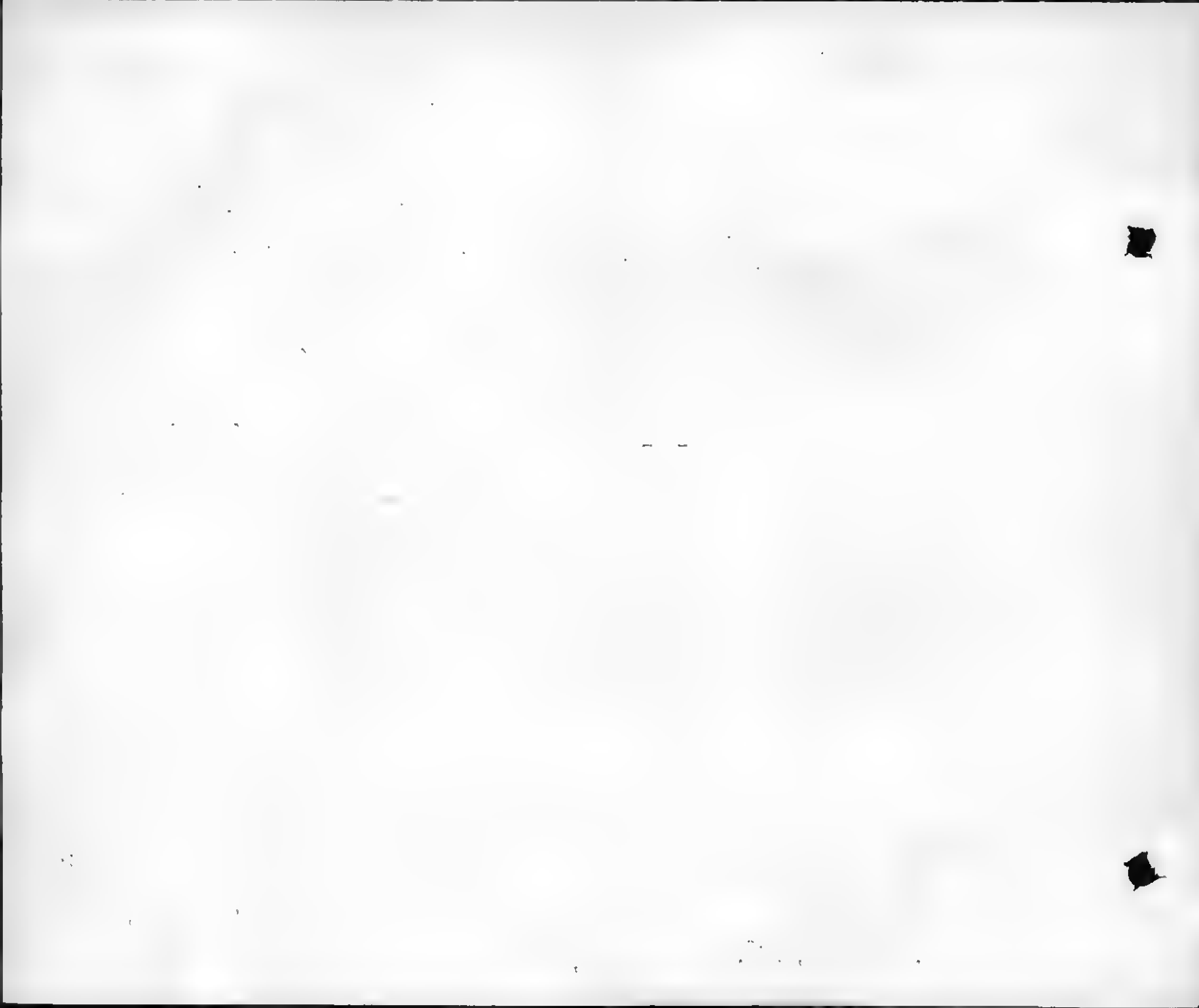
may be signed by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**UNITED STATES DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

12785

12772

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>16 days</u>				d. STREET ADDRESS <u>12100 - Dexter Ave. #1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Martin</u> Middle <u>Alfred</u> Last <u>DeBroske</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>8</u> Year <u>1961</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/27/88</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>salesman</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Michael L. DeBroske</u>				14. MOTHER'S MAIDEN NAME <u>? UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>577-03-3453A</u>		17. INFORMANT <u>Eva C. DeBroske</u> Address <u>Same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>AMyotrophic Lateral Sclerosis</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH <u>2-3 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-31</u> 19 <u>61</u> to <u>11-8-61</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>11-8-61</u> 19 <u>61</u> , and that death occurred at <u>4:45 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Morris Perry</u>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>MORRIS PERRY</u>	
22d. ADDRESS <u>11602 Georgia Ave Silver Spring, Md.</u>				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11/11/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE'S COUNTY, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Zisk</u> ADDRESS <u>6434 GEORGIA AVENUE</u>				25a. REC'D BY REGISTRAR <u>NOV 10 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
24. FUNERAL DIRECTOR'S NAME (Type) <u>WARNER E. PUMPHREY, INC.</u>				25c. ADDRESS <u>SILVER SPRING, MARYLAND</u>		25d. DATE	



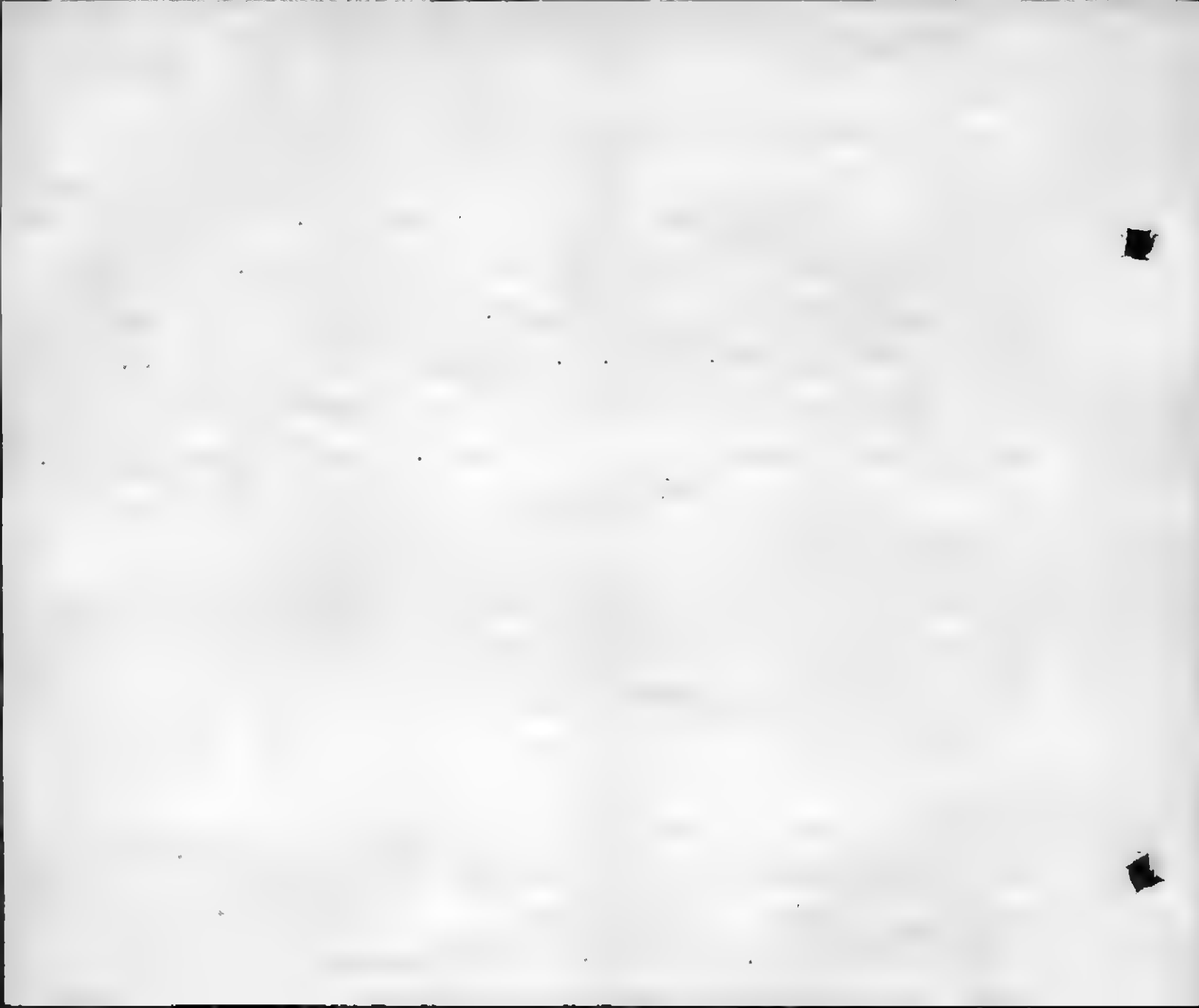
16  
FOR STATE  
HEALTH DEPT.

THIS MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

MEDICAL CERTIFICATION

<div> <div> <div>16</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>12786</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> </div> <div> <div>12773</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> </div> </div>															
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN <u>MDA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hosp</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>35 Kensington</u> d. STREET ADDRESS <u>3919 Decatur St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) <u>Stanley Albert</u>		<b>4. DATE OF DEATH</b> Last <u>Nov.</u> Month <u>28</u> Day <u>69</u> Year		<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		<b>8. DATE OF BIRTH</b> <u>Feb. 16, 1901</u>		<b>9. AGE</b> (In years last birthday) <u>60</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Engineer Custodian of Mont. Co. Schools</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Schools of Mont. Co.</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maine</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Nathaniel Densmore</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Amelia Beetcher</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>  </u>		<b>17. INFORMANT</b> <u>Stanley E. Densmore (Son) Hyattsville, Md.</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>  </u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>  </u> DUE TO (c) <u>  </u>												INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)															
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> <b>Accident</b> <input type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined manner</b> <input type="checkbox"/>															
<b>ACTUAL</b> <u>James J. Brochart</u> <b>NAME (Type)</b>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>		<b>DATE SIGNED</b> <u>11.29.61</u>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>				<b>22b. DATE THEREOF</b> <u>12/2/61</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Oakdale Cemetery</u>				<b>22d. LOCATION (City, town, or country)</b> (State) <u>Middleton, Mass.</u>					
<b>23. FUNERAL DIRECTOR</b> <u>Raymond A. Ziska</u> <b>ADDRESS</b> <u>8434 GEORGIA AVENUE</u> <u>WARNER E. PUMPHREY, INC. SILVER SPRING, MARYLAND</u>				<b>24a. REC'D BY REGISTRAR</b> <u>NOV 30 '61</u>				<b>24b. REGISTRAR'S SIGNATURE</b> <u>  </u>							



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

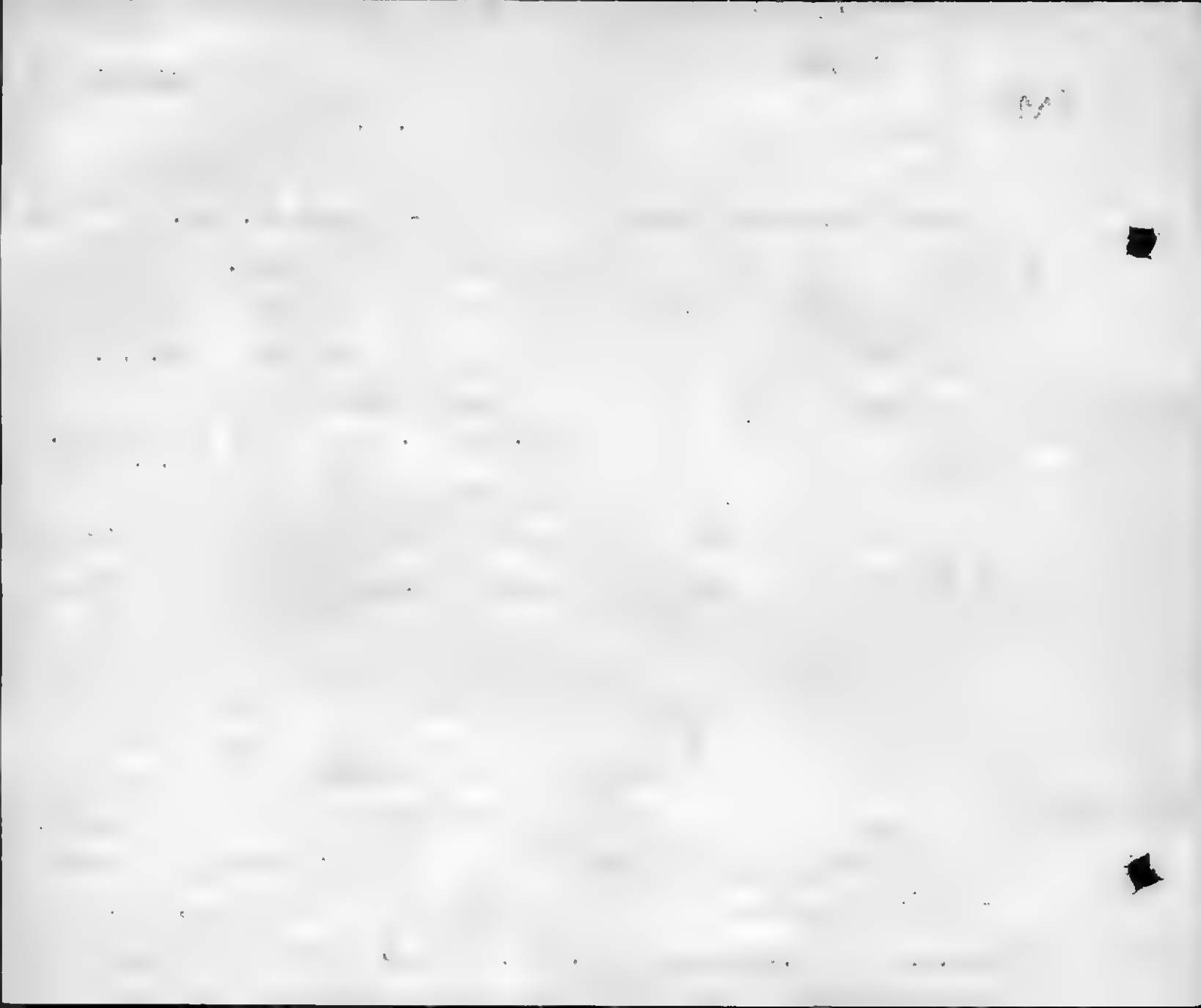
12787

## CERTIFICATE OF DEATH

12774

<b>1. PLACE OF DEATH</b> COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY in 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Resmor Sanitarium &amp; Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if inst. facility; residence before admission) a. STATE <u>Wash. D.C.</u> b. COUNTY _____ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>2910-Tennynson St. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Clara E Douglas</u> 5. SEX <u>female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF DEATH <u>Nov. 3 1961</u> 9. AGE (in years last birthday) <u>88</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>John Casey</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> 16. SOCIAL SECURITY NO. <u>no</u> 17. INFORMANT <u>Mrs. Frank J. Wilson, 2910 Tennynson St. NW Wash, D.C.</u>		14. MOTHER'S MAIDEN NAME <u>Mary Vermillion</u> 18. INTERVAL BETWEEN ONSET AND DEATH <u>2 mo</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Cerebral artery thrombosis</u> (b) <u>Congestive Heart Failure</u> (c) <u>Arteriosclerotic heart disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (e) _____			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) _____			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (1) (this hospital) attended the deceased from <u>July 4, 1959</u> to <u>Nov 3, 1961</u> , that (1) (we) last saw the deceased alive on <u>Nov 3, 1961</u> , and that death occurred <u>11:25 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>James J. Foster</u> 22c. PHYSICIAN'S NAME (Type) <u>JAMES J. FOSTER</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>11/4/61</u> 22d. ADDRESS <u>1746 K St N.W. Wash D.C.</u>	
23b. DATE THEREOF <u>11/6/61</u> 24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co., 2901 14th St. N.W.</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u> 25a. REC'D BY REGISTRAR <u>NOV 6 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

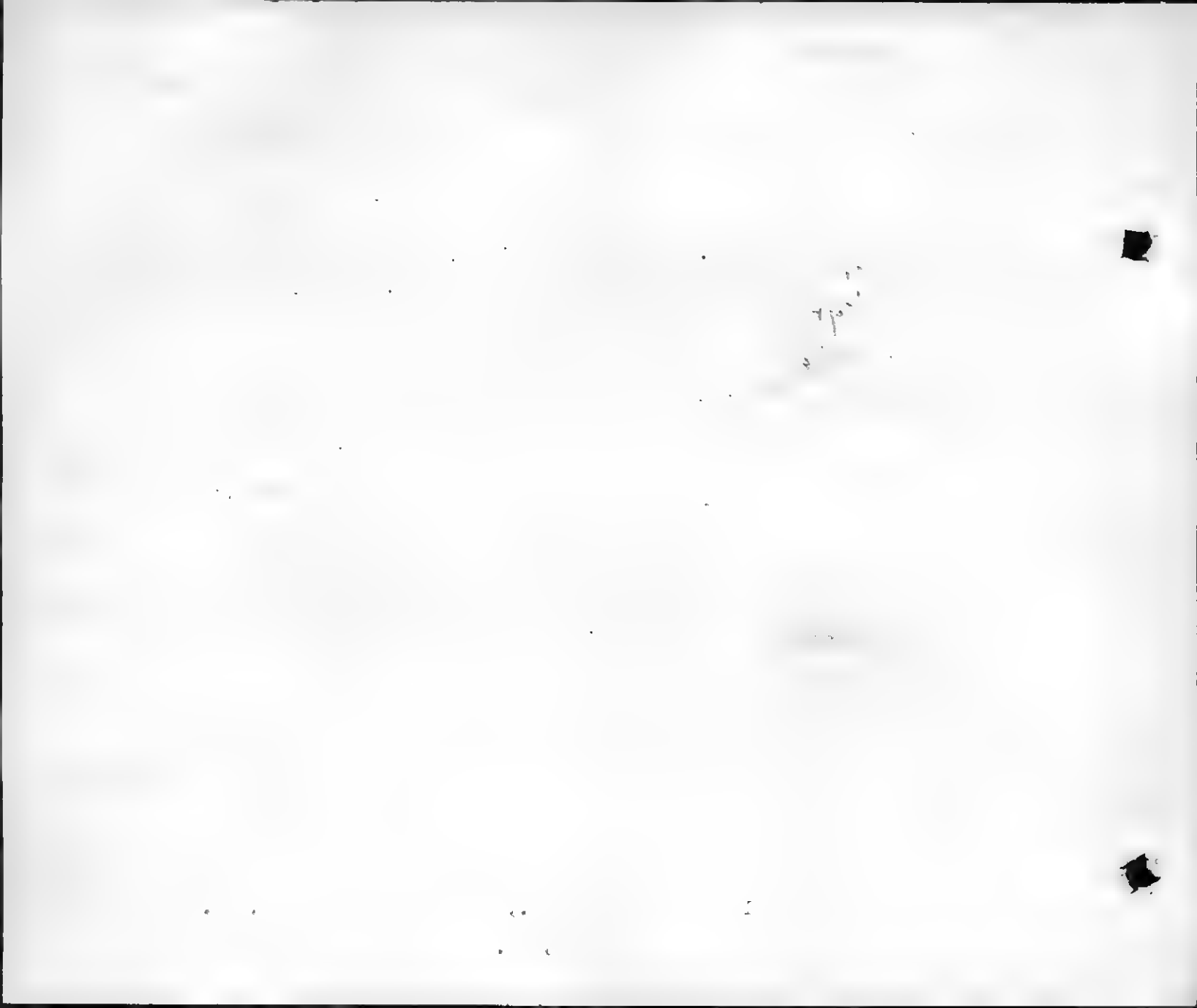


**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

12788

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Helen Cornelia Duffin</u> First Middle Last				4. DATE OF DEATH <u>11</u> Month <u>23</u> Day <u>1961</u> Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 13, 1897</u>	
9. AGE (In years last birthday) <u>64</u> yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Frederick M. Howard</u>				14. MOTHER'S MAIDEN NAME <u>Mary Wood</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>577-14-0653</u>		17. INFORMANT <u>Evelyn Mackey, daughter, same</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion, acute, recurrent</u>							
420.1 DUE TO <u>Arteriosclerotic C-V Disease</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Diabetes Mellitus, duration 20 yrs.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>11-12-1960</u> to <u>11-23-1961</u> , that (I) (we) last saw the deceased alive on <u>11-22-1961</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Clive E. Jackson</u> M.D.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>CLIVE E. JACKSON</u>				22d. ADDRESS <u>202 Martin Ln., Rockville, Md.</u>			
23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/26/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park.,</u>		23d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden -</u> ADDRESS <u>Rockville, Md.</u>				25a. REC'D BY REGISTRAR <u>NOV 30 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12789

## CERTIFICATE OF DEATH

12776

### PLACE OF DEATH

COUNTY **Montgomery**

STATE **MARYLAND**

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  
**Olney**

c. LENGTH OF STAY IN 1b  
**2 days**

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  
**Montgomery General Hospital**

### 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

STATE **Maryland** COUNTY **Montgomery**

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  
**X Gaithersburg -- Rural**

d. STREET ADDRESS  
**Rt. #1 Box 251**

e. IS RESIDENCE ON A FARM?  
YES ☐ NO ☒ **unk**

### 3. NAME OF DECEASED

First **HOWARD**

Middle **COLLIER**

Last **DUVALL**

4. DATE OF DEATH

Month **11-** Day **22** Year **19 61**

5. SEX  
**Male**

6. COLOR OR RACE  
**negro**

7. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH  
**5-23-1896**

9. AGE (in years last birthday)  
**65 yrs.**

IF UNDER 1 YEAR  
Months Days

IF UNDER 24 HRS.  
Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)  
**Maryland**

12. CITIZEN OF WHAT COUNTRY?  
**U.S.A.**

### 13. FATHER'S NAME

**Lott Duvall**

### 14. MOTHER'S MAIDEN NAME

**Nora Warfield**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  
**unk**

16. SOCIAL SECURITY NO.

17. INFORMANT  
**hospital records**

Address

### 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

**541.1** DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

**Peritonitis Generalized  
Perforated Duodenal Ulcer**

INTERVAL BETWEEN ONSET AND DEATH

**5 days  
5 days**

### PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)

20c. TIME OF INJURY  
Hour a.m. **19** p.m.

20d. INJURY OCCURRED  
While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from **11/22/61** to **11/22/61**, that (I) (we) last saw the deceased alive on **11/22/61**, and that death occurred **3:00 PM** on **11/22/61**, from the causes and on the date stated above.

22a. SIGNATURE

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS. ☐

22d. ADDRESS

**Sandy Spring, Md.**

22b. DATE SIGNED  
**11/23/61**

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF  
**11/27/61**

23c. NAME OF CEMETERY OR CREMATORY  
**Emory Grove.,**

23d. LOCATION (City, town or county)  
**Emory Grove, Md.**

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

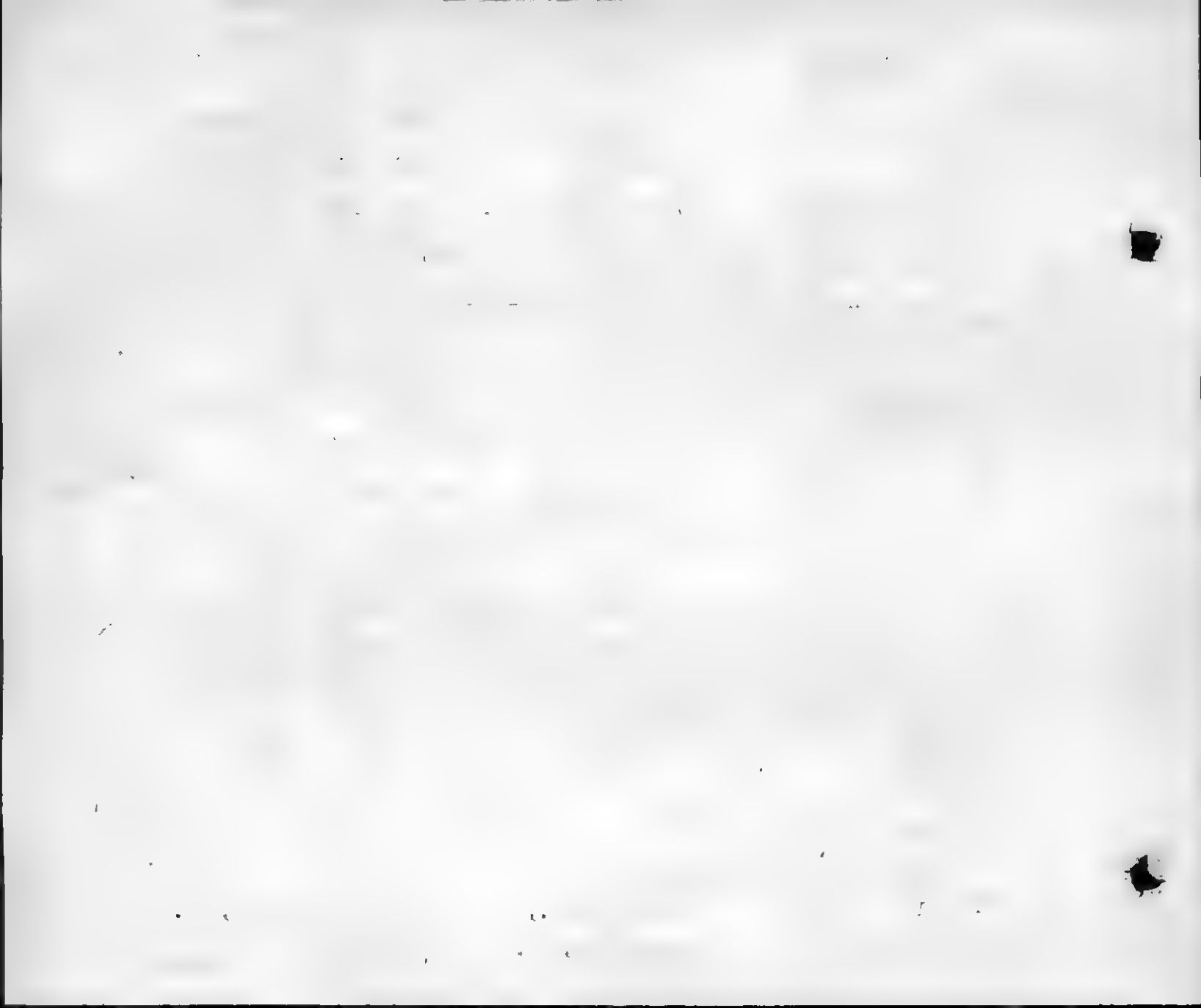
ADDRESS  
**Rockville, Md.**

25a. REC'D BY REGISTRAR  
**NOV 29 '61**

25b. REGISTRAR'S SIGNATURE  
**Arthur S. House**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# UNITED STATES DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

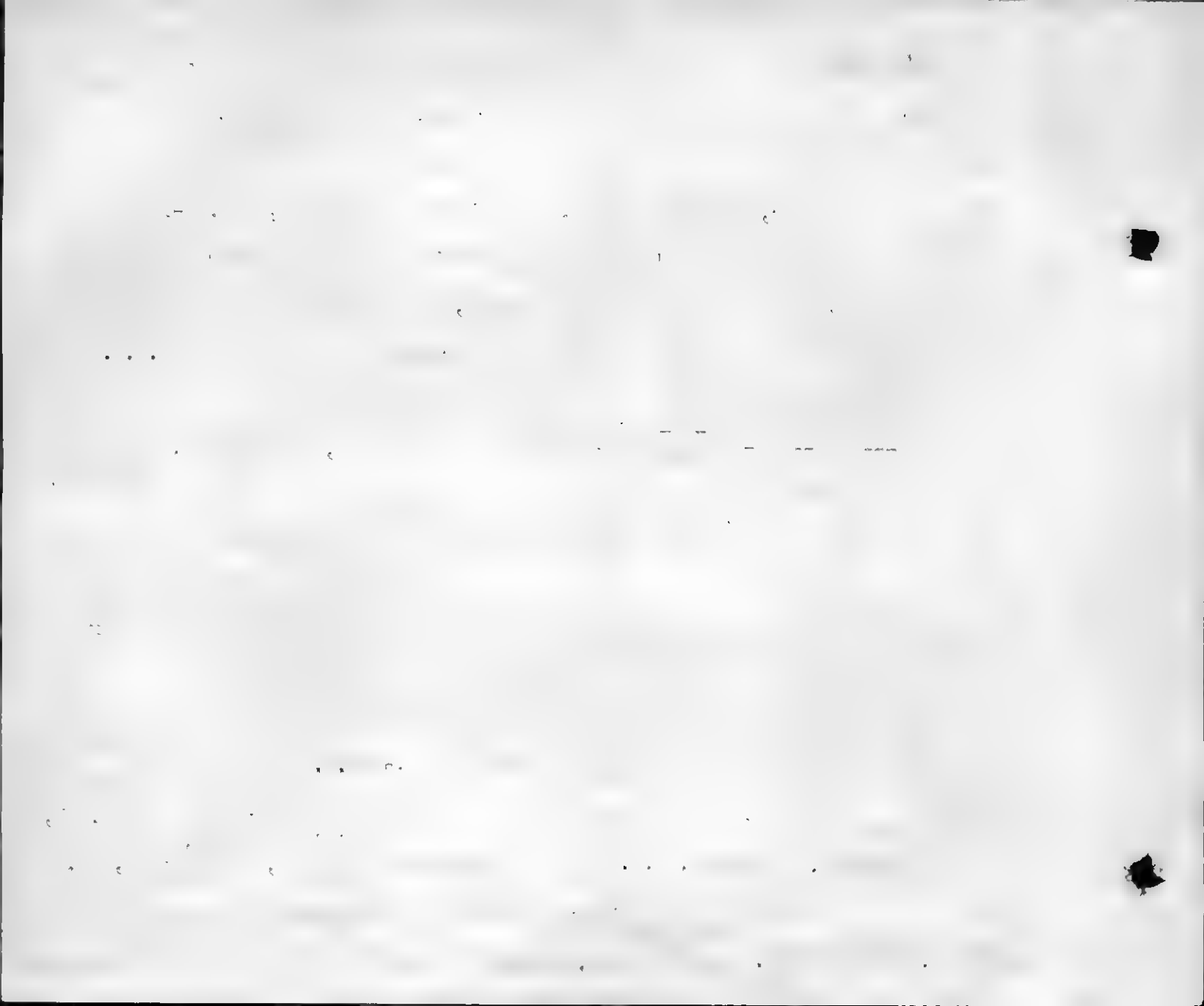
## CERTIFICATE OF DEATH

12790

12777

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>9 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Montgomery</u></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> d. STREET ADDRESS <u>10817 Georgia Avenue, Apt. T-1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <u>Judy O'Keefe Earmelli</u>		<b>4. DATE OF DEATH</b> Month <u>November</u> Day <u>20</u> Year <u>19 61</u>		<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>July 4, 1928</u>		<b>9. AGE</b> (In years) IF UNDER 1 YEAR: <u>33</u> yrs. Months <u>33</u> Days <u>33</u> Hours <u>33</u> Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>							
<b>13. FATHER'S NAME</b> <u>David Sherman Younce</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Irabelle Devoard</u>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>222-18-4493</u> <b>17. INFORMANT</b> <u>The Medical Record</u> <span style="float: right;">Address</span>				<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> 204.3 DUE TO <u>Acute myelogenous leukemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>7 weeks</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part I of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>19</u> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>11 Nov 1961</u> to <u>20 Nov 1961</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>20 Nov 1961</u> and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.											
<b>22a. SIGNATURE</b> <u>Edward S. Henderson M.D.</u>				<b>22b. DATE SIGNED</b> <u>Nov. 21, 1961</u>							
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>EDWARD S. HENDERSON, M.D.</u>				<b>22d. ADDRESS</b> <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>11/24/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Gate of Heaven Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Montgomery Maryland</u>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Warner E. Pimphrey Inc.</u>				<b>25a. REC'D BY REGISTRAR</b> <u>DATE NOV 24 '61</u>							
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hines</u>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH STATE DEPARTMENT OF HEALTH

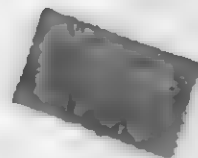
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12791

## CERTIFICATE OF DEATH

12778

1. PLACE OF DEATH COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Gloucester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gloucester</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Carroll Hall Sanitarium</b>		d. STREET ADDRESS <b>None</b>	
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>Lee</b> Last <b>EDWARDS</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>8</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 23, 1874</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Claiborn T. Roane</b>		14. MOTHER'S MAIDEN NAME <b>Ann E. Medlicott</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Sanitarium records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X HYPERTENSIVE HEART DISEASE</b> DUE TO (b) <b>GENERALIZED ARTERIOSCLEROSIS</b> DUE TO (c) <b>ESSENTIAL HYPERTENSION</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>SEIZURES</b>			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>JULY 31, 1960, to NOV. 8, 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov. 8, 1961</b> , and that death occurred <b>at 10:35 M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Henry M. Lowden</b>		22b. DATE SIGNED <b>11/8/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Henry M. Lowden</b>		22d. ADDRESS <b>5206 NORWAY DR. CHERRY CHASE - MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/10/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Gloucester Point Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Gloucester, Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>NOV 10 61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>		DATE	



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1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed, within 24 hours after death, by a physician who has attended the deceased. The law also requires that the death certificate be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
12792  
12779  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MONTGOMERY GENERAL HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING RT. 2</b> d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CLARENCE BENJAMIN EDWARDS</b>		4. DATE OF DEATH <b>NOVEMBER 4 1961</b>		9. AGE (in years last birthday) <b>52</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNEMPLOYED FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>HENRY EDWARDS</b>		14. MOTHER'S MAIDEN NAME <b>ARIANA GREENFIELD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>-</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>HOSPITAL RECORDS</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>441X BROENOPNEUMONIA BILATERAL</b> <b>Pneumosis of LIVER</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) <b>-</b>		INTERVAL BETWEEN ONSET AND DEATH <b>-</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-</b>		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-</b>		20f. (City or town) (County) (State) <b>-</b>	
21. I certify that (I) <del>XXXXXX</del> attended the deceased from <b>10-30</b> , 19 <b>61</b> , to <b>11-4</b> , 19 <b>61</b> , that (I) <del>XXXX</del> last saw the deceased alive on <b>11-4</b> , 19 <b>61</b> , and that death occurred at <b>10:25 AM</b> from the causes and on the date stated above.		22a. SIGNATURE <b>Ad. B. [Signature]</b>		22b. DATE SIGNED <b>NOV 8 '61</b>	
22c. PHYSICIAN'S NAME (Type) <b>CHARLES H. LIGON, M.D.</b>		22d. ADDRESS <b>SANDY SPRING, MARYLAND</b>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF <b>Burial Nov 9-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Burtonsville - Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b>		25a. READ BY REGISTRAR <b>[Signature]</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

16.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

**MARYLAND STATE DEPARTMENT OF HEALTH**

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12793

## CERTIFICATE OF DEATH

12780

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>District of Columbia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		b. COUNTY <b>Washington</b>	
c. LENGTH OF STAY IN b. <b>19 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47X</b>	
3. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md</b>		d. STREET ADDRESS <b>3740 McKinley Street, N.W.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Mary Elizabeth Eldridge</b>		4. DATE OF DEATH Month <b>November</b> Day <b>12</b> Year <b>1961</b>	
5. SEX <b>Female</b>		8. DATE OF BIRTH <b>27 August 1954</b>	
6. COLOR OR RACE <b>White</b>		9. AGE (In years last birthday) <b>7</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>District of Columbia</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME: <b>Lynn E. Eldridge</b>		14. MOTHER'S MAIDEN NAME <b>Alzore Elizabeth Hale</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>The Medical Records</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) <b>Malignant Embryoma of Kidney</b>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>180X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Sepsis</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 24, 1961</b> to <b>Nov. 12, 1961</b> that (I) (we) last saw the deceased alive on <b>Nov. 12, 1961</b> , and that death occurred at <b>5:30 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Geo. H. Porter, III</b>		22b. DATE <b>Nov. 12, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>GEORGE H. PORTER, III, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>11-15-1961</b>	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State) <b>Meredith, New Hampshire</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Sanders Sons, Inc.</b>		25a. REC'D BY REGISTRAR <b>NOV 16 '61</b>	
ADDRESS <b>1756 Pa Ave NW</b>		25b. REGISTRAR'S SIGNATURE	

VR A15 (4)  
15M 9/60

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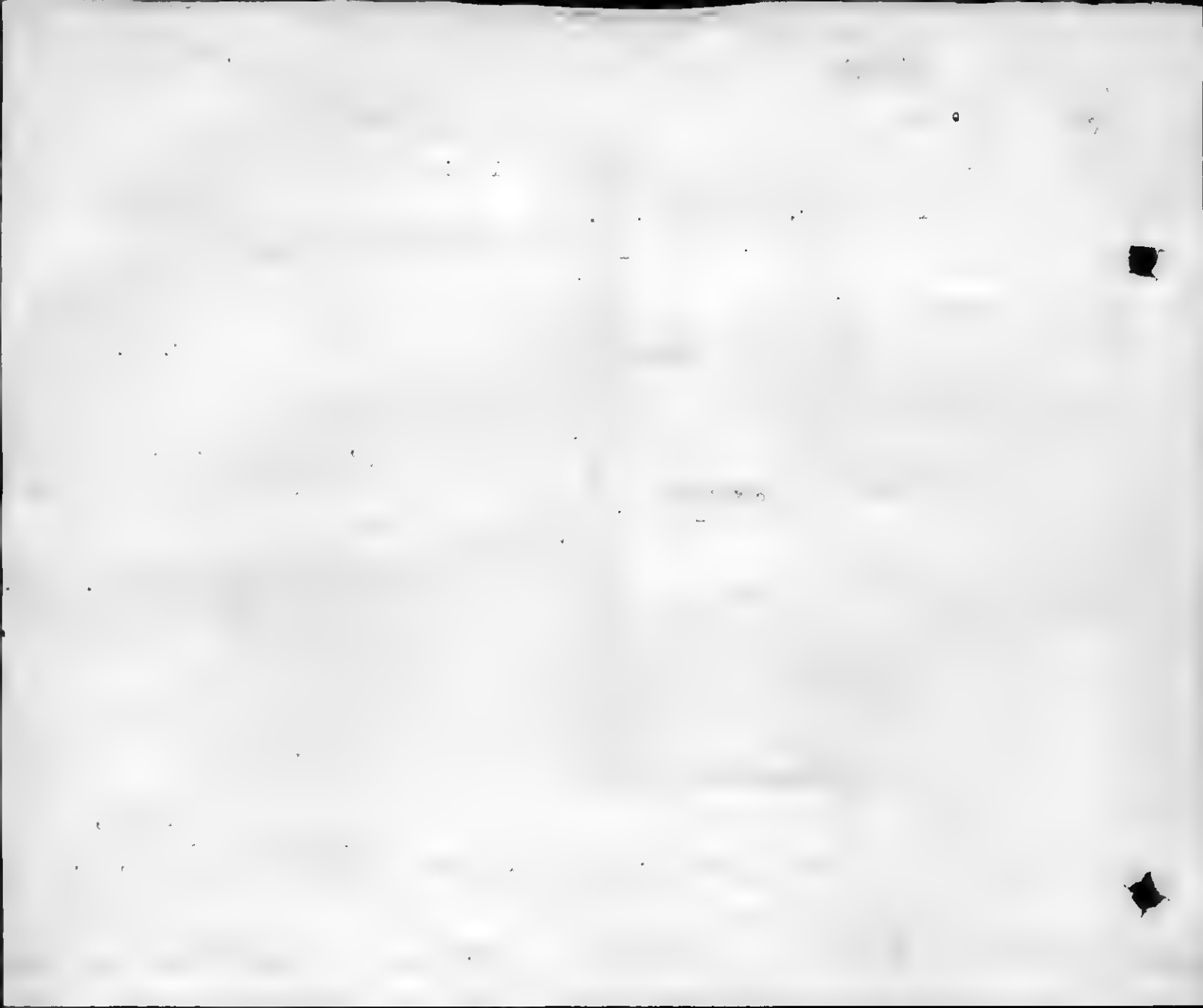
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

12794

12781

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN b <b>16 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY <b>Iselin</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>129 Worth Street</b> d. STREET ADDRESS <b>Iselin</b>		<b>3. NAME OF DECEASED</b> (Type or print) <b>Deborah</b> First Middle Last <b>Enden</b>		<b>4. DATE OF DEATH</b> <b>November 21 19 61</b> Month Day Year		<b>e. IS RESIDENCE ON A FARM?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>26 December 1957</b>		<b>9. AGE</b> (In years, last birthday) <b>3 yrs.</b> IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours M.n.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Child</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>None</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>New York</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>13. FATHER'S NAME</b> <b>Frederick Enden</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Helen Eisenberger</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes, give year or dates of service) <b>16. SOCIAL SECURITY NO</b> <b>None</b> <b>17. INFORMANT</b> <b>The Medical Record</b> <b>Address</b> <b>The Clinical Center, Bethesda 14, Maryland</b>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) <b>PART I. DEATH WAS CAUSED BY:</b> <b>754.0</b> <b>IMMEDIATE CAUSE (a)</b> <b>congestive heart failure and Cardio Vascular Accident</b> <b>48 hours</b> <b>754.0</b> <b>DUE TO</b> <b>Post-operative Tetralogy de Fallot with Prosthetic</b> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>(b)</b> <b>Blalock Shunt Anastomosis</b> <b>12 days</b> <b>(c)</b> <b>Congenital Heart Disease - Tetralogy de Fallot</b> <b>3 yrs. 11 mo.</b>		<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Hour e.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> <b>November 5, 1961, to November 21, 1961</b>		<b>20g. (County)</b> <b>that (s) (we) last saw the deceased alive on November 21 1961, and that death occurred at 9:32 AM from the causes and on the date stated above.</b>	
<b>21. I certify that</b> (If (this hospital) attended the deceased from... <b>November 5, 1961, to November 21, 1961</b> ... that (s) (we) last saw the deceased alive on <b>November 21 1961</b> , and that death occurred at <b>9:32 AM</b> from the causes and on the date stated above.		<b>22a. SIGNATURE</b> <i>Allan Goldblatt</i>		<b>22b. DATE SIGNED</b> <b>November 21, 1961</b>		<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Allan Goldblatt, M.D.</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>		<b>23b. DATE THEREOF</b> <b>11-22-61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b>		<b>23d. LOCATION</b> (City, town or county) <b>NEW YORK</b>		<b>23e. REC'D BY REGISTRAR</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>BERNARD DANZANSKY &amp; SONS</b>		<b>24a. ADDRESS</b> <b>3501 14th St. NW</b>		<b>25a. REC'D BY REGISTRAR</b> <b>NOV 24 '61</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>Chas S. Harris</i>			



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12795

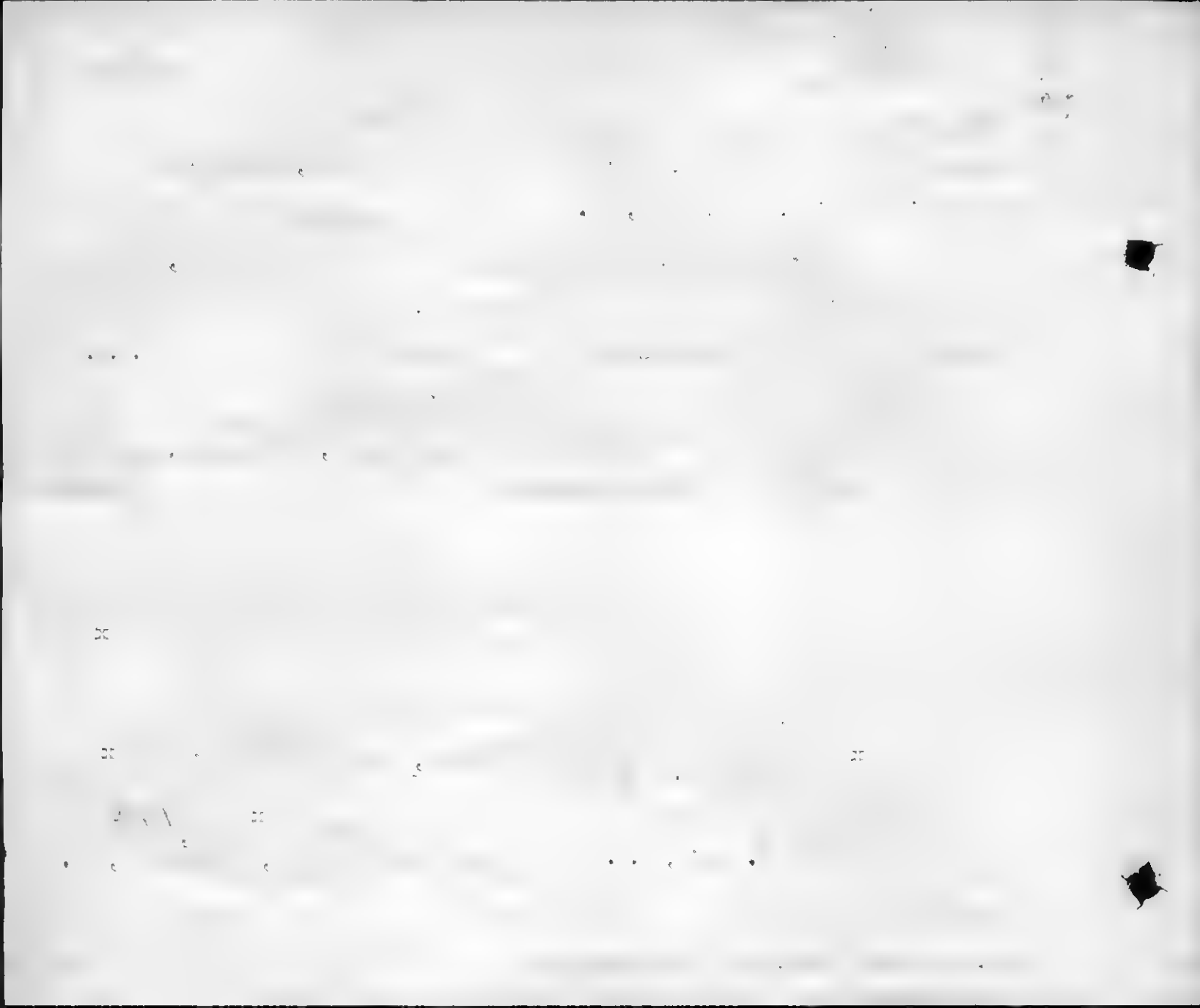
12782

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(I)

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Florida</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bay Harbor Island, Miami Beach</u> d. STREET ADDRESS <u>9601 West Broadview Drive</u>			
c. LENGTH OF STAY IN 1b <u>19 Days</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Solomon (None) Engel</u> First Middle Last				<b>4. DATE OF DEATH</b> <u>November 4, 1961</u> Month Day Year			
<b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				<b>8. DATE OF BIRTH</b> <u>October 11, 1913</u> Last First Middle			
<b>9. AGE</b> (In years, last birthday) <u>48</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Mins. _____ IF UNDER 24 HRS.: _____				<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Builder</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Construction</u>			
<b>11. BIRTHPLACE</b> (Country & State, or foreign country) <u>Poland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>				<b>13. FATHER'S NAME</b> <u>Philip Engel</u> <b>14. MOTHER'S NAME</b> <u>Paula Rosenthal</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u> <b>16. SOCIAL SECURITY NO.</b> <u>Unascertainable</u> <b>17. INFORMANT</b> <u>The Medical Records</u> <u>The Clinical Center, Bethesda 14, Maryland</u>				<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple myeloma</u> DUE TO <u>203 X</u> Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____ PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u>15 months</u>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____				<b>20c. TIME OF INJURY</b> Month, Day, Year _____ Hour a.m. _____ p.m. <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ <b>20f. (City or town)</b> _____ (County) _____ (State) _____				<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>October 16, 1961</u> to <u>November 4, 1961</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>November 4, 1961</u> , and that death occurred at <u>8:50 PM</u> , from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <u>Robert H. Levin</u> <b>22c. PHYSICIAN'S NAME</b> (Type) <u>Robert H. Levin, M.D.</u>				<b>22b. DATE SIGNED</b> <u>11/5/61</u> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <b>22d. ADDRESS</b> <u>The Clinical Center, National Institutes Of Health, Bethesda 14, Md.</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Removal</u>		<b>23b. DATE THEREOF</b> <u>Nov 5, 1961</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Beth David</u>		<b>23d. LOCATION</b> (City, town or county) <u>Elmont, New York</u> (State) _____	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Sol. Levinson &amp; Bros. Inc.</u> ADDRESS <u>6010 Reist Road</u>				<b>25a. RECD BY REGISTRAR</b> <u>NOV 7 61</u> DATE _____			
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hirsch</u>				_____			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/58

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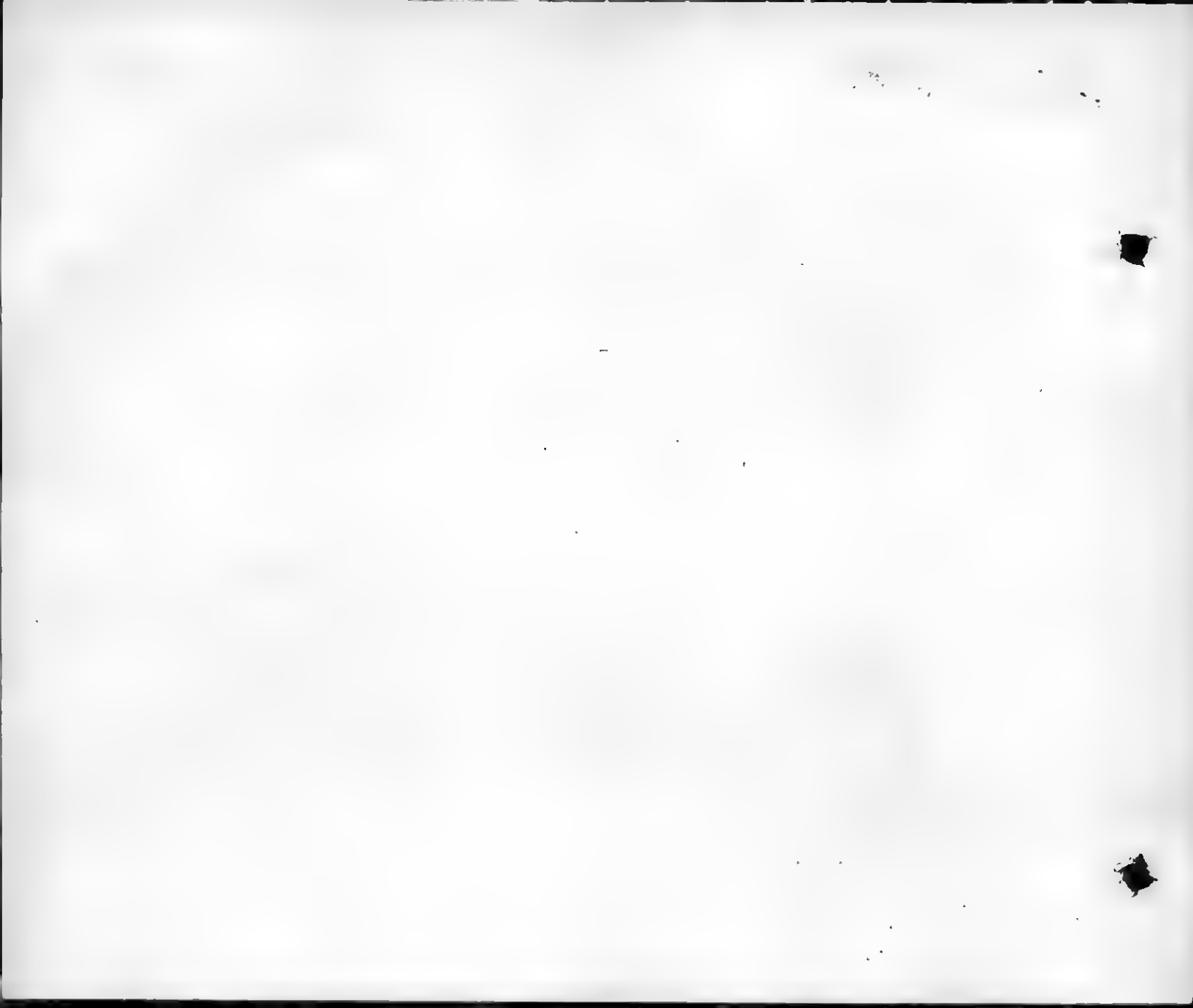
12796

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Echo</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>58 Glen Echo</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>107 Harvard Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lydia</b> Middle <b>E</b> Last <b>Fagan</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>10</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 6, 1900</b>
9. AGE (In years last birthday) <b>61</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>4</b>	11. IF UNDER 24 HRS Hours <b></b> Min <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Wear</b>		14. MOTHER'S MAIDEN NAME <b>Emma Wood</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Jane Carter-daughter</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial Infarction</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>coronary occlusion</b> DUE TO (c) <b>coronary arterio-sclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 mo.</b> <b>3 mo.</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 1959</b> to <b>11-10, 1961</b> , that (I) (we) last saw the deceased alive on <b>11-10, 1961</b> , and that death occurred at <b>4:48</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>R. M. Tillet, Jr.</b>		22b. DATE SIGNED <b>11-10-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>R. M. Tillet</b>		22d. ADDRESS <b>4701-Mass. Ave. N.W. Wash. D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/13/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 13 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>			

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MEDICAL CERTIFICATION



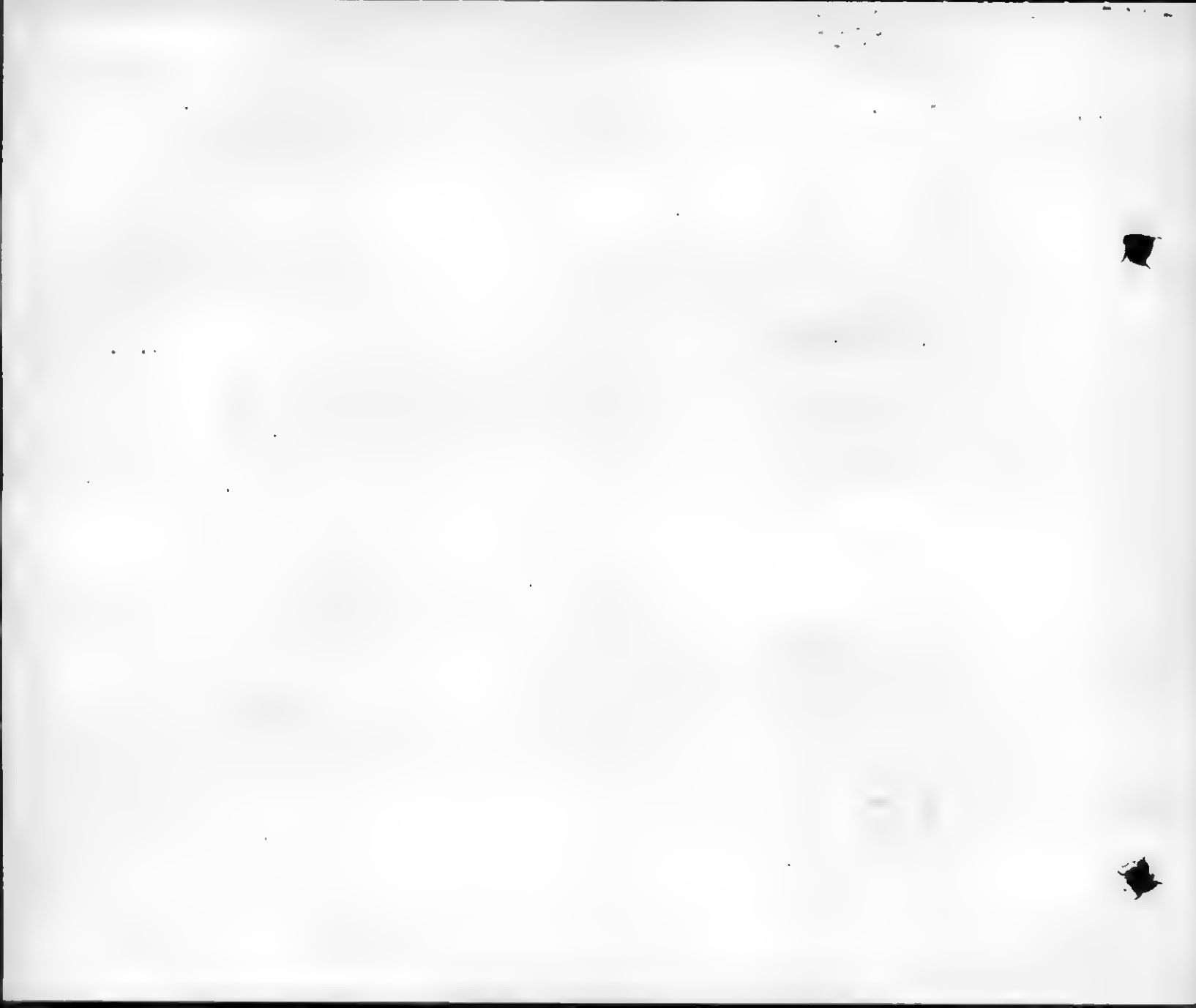
may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

12797

12784

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kensington Gardens Sanitarium</b>				d. STREET ADDRESS <b>10119 Crestwood Road</b>			
3. NAME OF DECEASED (Type or print) First <b>Robert E.</b> Middle <b>Fellers</b> Last				4. DATE OF DEATH Month <b>November</b> Day <b>5</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 24, 1892</b>	
9. AGE (In years last birthday) <b>69</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Government employee</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>John D. Fellers</b>				14. MOTHER'S MAIDEN NAME <b>Katie E. Richard</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT <b>HOSPITAL RECORDS -</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular thrombosis</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>10+ yrs.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19__		20d. INJURY OCCURRED While _____ Not while _____ at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <b>June 1959</b> to <b>Nov. 5, 1961</b> , that (I) (we) last saw the deceased alive on <b>11/3</b> 1961, and that death occurred at <b>6:40 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>E. H. Aschenbach</b>				22b. DATE SIGNED <b>11/5/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>E. H. Aschenbach</b>				22d. ADDRESS <b>1841 Col. Rd., N.W. Wash., D.C.</b>			
23a. BURIAL, CREMATION, REMOVAL, ETC.		23b. DATE THEREOF <b>11-8-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEM.</b>		23d. LOCATION (City, town, or county) (State) <b>WASHINGTON D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Deal Funeral Home</b>				25a. REC'D BY REGISTRAR <b>NOV 16 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	



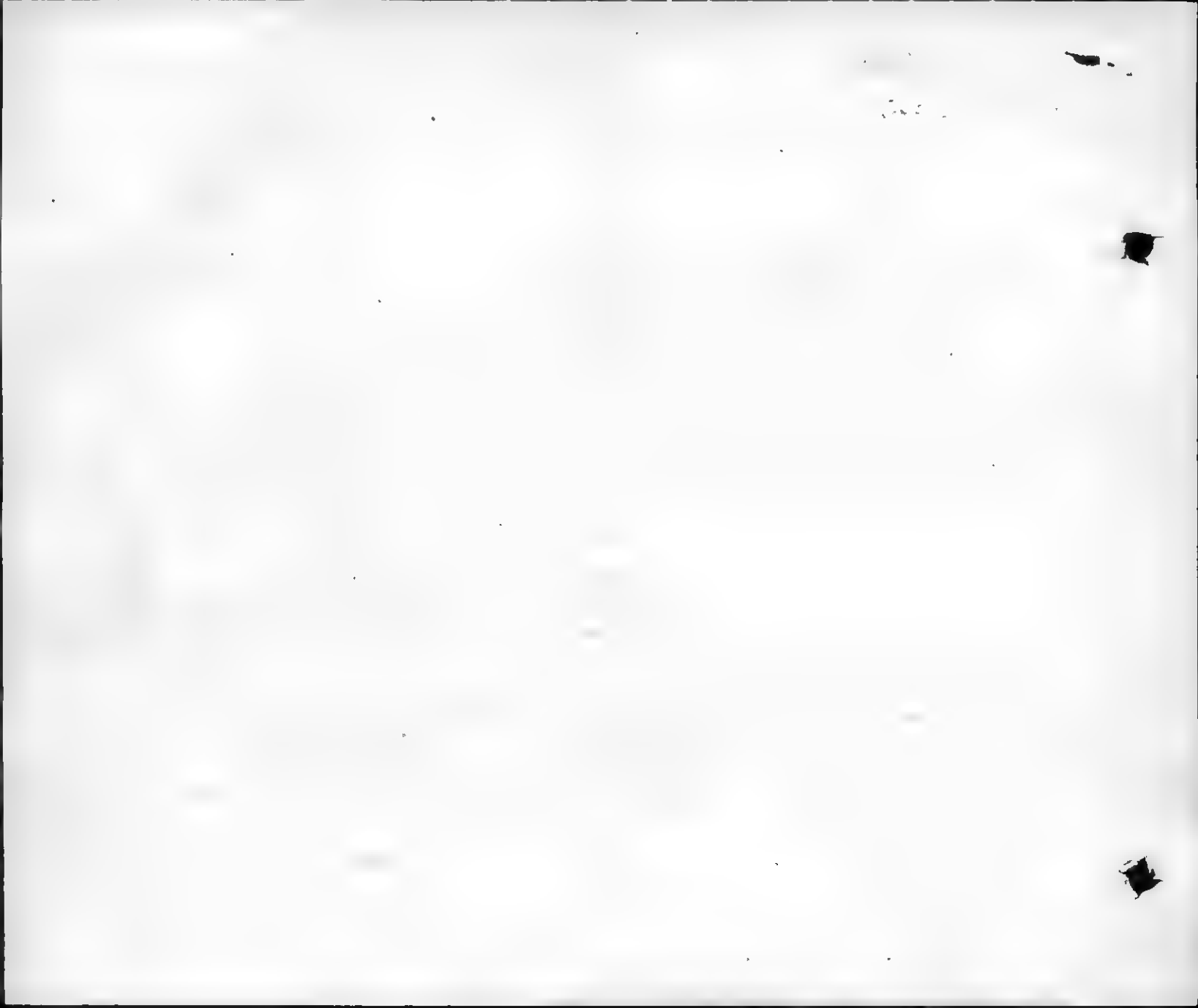
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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Mont.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>30 Chesd 2</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, 16, D.C.</i>	
c. LENGTH OF STAY IN 1b <i>1 hr. 5 min.</i>		d. STREET ADDRESS <i>6304 - Mass Ave. N.W.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Stu burban.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Richard</i> Middle <i>Francis</i> Last <i>Field</i>		4. DATE OF DEATH Month <i>November</i> Day <i>7</i> Year <i>1961</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 15, 1896</i>
9. AGE (in years last birthday) <i>64</i> yrs		10. IF UNDER 1 YEAR Months <i>6</i> Days <i>4</i> Hours <i>15</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clark</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>drug stores</i>	
11. BIRTHPLACE (State or foreign country) <i>New Hampshire</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>John F. Field</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Sullivan</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>yes</i>		16. SOCIAL SECURITY NO. <i>57807-4783</i>	
17. INFORMANT <i>daughter</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Massive Myocardial Infarction</i> DUE TO (b) <i>Coronary Artery Occlusion</i> DUE TO (c) <i>Coronary artery sclerosis</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Hypertension</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <i>9</i> p. m. 19 <i>61</i>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <i>7:46</i> to <i>7:40</i> , 1961, that (I) (we) last saw the deceased alive on <i>6 Nov. 1961</i> , and that death occurred at <i>7:40</i> AM, from the causes and on the date stated above.			
22a. SIGNATURE <i>Merton L. White</i>		22b. DATE SIGNED <i>Nov 11</i>	
22c. PHYSICIAN'S NAME (Type) <i>Merton L. White</i>		22d. ADDRESS <i>11134 Georgia Ave Silver Spring Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11/10/61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cem.</i>		23d. LOCATION (City, town, or county) (State) <i>Silver Spring, Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey, Bethesda, Maryland</i>		25a. REC'D BY REGISTRAR <i>NOV 10 61</i>	
25b. REGISTRAR'S SIGNATURE <i>Chas. L. Hines</i>			

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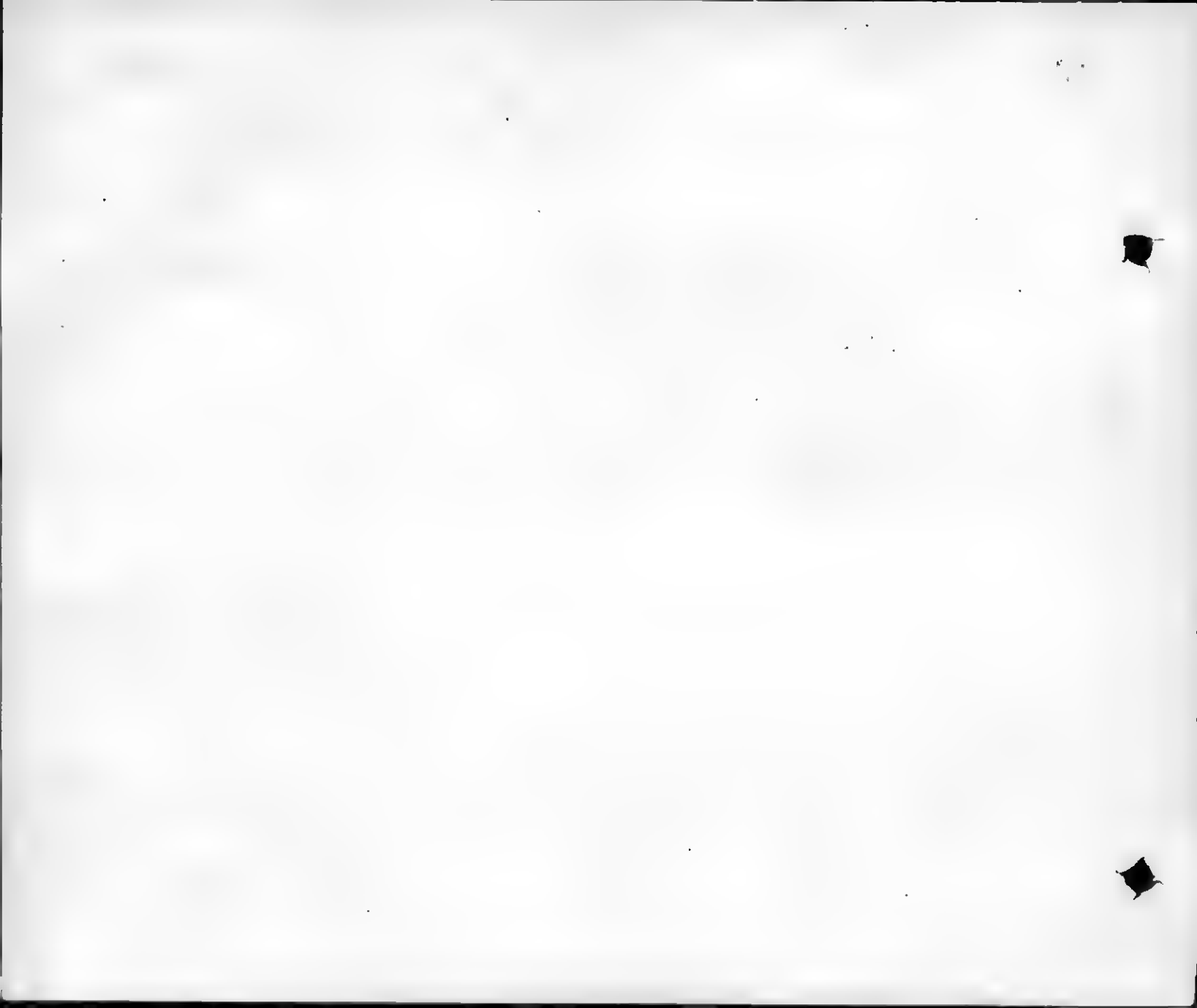
MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

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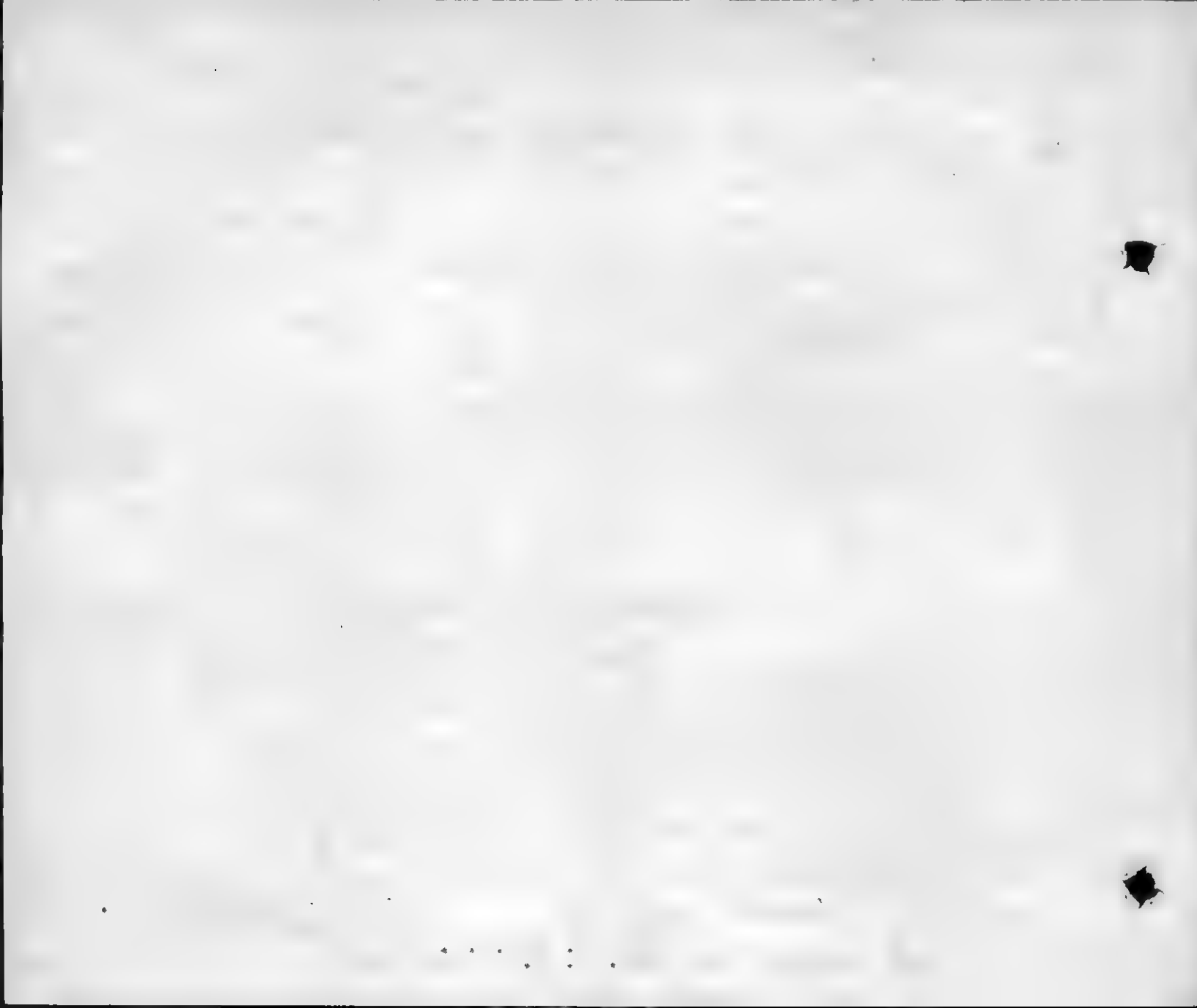
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>3 hours</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>6300 Tuba Lane</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Infant</u> Middle <u>Girl</u> Last <u>Finch</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>3</u> Year <u>1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 3, 1961</u>	
9. AGE (In years lost birthday) yrs <u>3</u>		IF UNDER 1 YEAR Months <u>3</u> Days <u>30</u>		IF UNDER 24 HRS Hours <u>3</u> Min. <u>30</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Rogers B. Finch</u>				14. MOTHER'S MAIDEN NAME <u>Barbara - Hine</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Father - Above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PREMATURITY</u> <u>176X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a m. p. m. <u>19</u>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/3, 1961</u> to <u>11/3, 1961</u> , that (I) (we) last saw the deceased alive on <u>11/3, 1961</u> , and that death occurred at <u>—</u> M, from the causes and on the date stated above							
22a. SIGNATURE <u>Ira W. Pearlman</u> M.D.				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>IRA. W. PEARLMAN, M.D.</u>	
22d. ADDRESS <u>4700 BRADLEY BLVD, CHEVY CHASE, MD.</u>				22e. REC'D BY REGISTRAR		22f. REGISTRAR'S SIGNATURE	
23a. BLR AL. (CREMATION) REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>11-4-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SUBURBAN HOSPITAL</u>		23d. LOCATION (City, town, or county) (State) <u>BETHESDA, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. Amelia Carter, Admin.</u> ADDRESS <u>OLD GEORGETOWN, BETHESDA, MD.</u>				25a. DATE <u>NOV 7 '61</u>		25b. REGISTRAR'S SIGNATURE <u>William L. Thomas</u>	

2074395XV0



VS. A15ME  
5M 9/60

Clifford L. Thomas



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

12801

12788

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>8 1/2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if first list on: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany Co.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>LaVale</u> d. STREET ADDRESS <u>47 LaVale Blvd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Allan</u> Middle <u>Carol</u> Last <u>Fisher, Sr.</u>				<b>4. DATE OF DEATH</b> Month <u>Nov.</u> Day <u>28</u> Year <u>1961</u>															
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>April 29, 1885</u>		<b>9. AGE</b> (In years last birthday) <u>76</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		<b>11. IF UNDER 24 HRS.</b> Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>							
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>District Car Distributor</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Western Maryland R.R.</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Pennsylvania</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>							
<b>13. FATHER'S NAME</b> <u>David Fisher</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Rachel Cessna</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or date of service)				<b>16. SOCIAL SECURITY NO.</b> <u>Unknown</u>				<b>17. INFORMANT</b> <u>Washington Sanitarium and Hospital Records</u> Address <u>  </u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, General</u> DUE TO (c) <u>  </u>												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>9 days</u> <u>15 years</u>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>																			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)															
<b>20c. TIME OF INJURY</b> Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that (I) (the hospital) attended the deceased from... 11-19-61 to... Nov 28, 1961 that (I) (we) last saw the deceased alive on Nov 27, 1961, and that death occurred at 5:20 AM from the causes and on the date stated above.</b>																			
<b>22a. SIGNATURE</b> <u>George B. Patrick, Jr.</u> M.D. <b>22c. PHYSICIAN'S NAME</b> (Type) <u>George B. Patrick, Jr. MD</u> <b>22b. DATE SIGNED</b> <u>11-28-61</u> <b>22d. ADDRESS</b> <u>9221 Colesville, Silver Spring, Md.</u>																			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Bur-Transit</u>				<b>23b. DATE THEREOF</b> <u>12/1/61</u>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Sunset Mem. Cemetery</u>				<b>23d. LOCATION</b> (City, town or county) (State) <u>Cumberland, Maryland</u>							
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Pumphrey, Bethesda, Maryland</u>								<b>25a. REC'D BY REGISTRAR</b>				<b>25b. REGISTRAR'S SIGNATURE</b> <u>Carlton L. Hume</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
12802  
1278

<b>1. PLACE OF DEATH</b> a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b> c. LENGTH OF STAY IN TB <b>20 YEARS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>4603 HARLING LANE</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b> d. STREET ADDRESS <b>4603 HARLING LANE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>JENNIE E. FOGG</b>		<b>4. DATE OF DEATH</b> Month <b>11</b> Day <b>17</b> Year <b>1961</b>	
<b>5. SEX</b> <b>F</b>	<b>6. COLOR OR RACE</b> <b>W</b>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>DEC 9, 1871</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		<b>9. AGE</b> (In years last birthday) <b>89</b> yrs. IF UNDER 1 YEAR: Months <b>89</b> Days <b>89</b> IF UNDER 24 HRS.: Hours <b>89</b> Min. <b>89</b>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>CAMPBELLFORD, ONTARIO</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>CANADA</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		<b>13. FATHER'S NAME</b> <b>THOMAS DUNK</b>	
<b>14. MOTHER'S MAIDEN NAME</b> <b>MARGERY THOMPSON</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b> <b>16. SOCIAL SECURITY NO.</b> <b>NO</b>	
<b>17. INFORMANT</b> <b>DAUGHTER</b> <b>BERNADINE GONDON</b>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (a) <b>BRONCHIAL PNEUMONIA</b> (b) <b>CEREBROVASCULAR ACCIDENT</b> (c) <b>ARTERIOSCLEROSIS, CEREBRAL &amp; GENERALIZED</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c). <b>3 days</b> <b>11 days</b> <b>YEARS</b>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>21. I certify that (I) (the hospital) attended the deceased from</b> <b>JUNE 1957</b> <b>to</b> <b>NOV 17, 1961</b> , that (I) (we) last saw the deceased alive on <b>NOV 15, 1961</b> , and that death occurred at <b>9 A.M.</b> from the causes and on the date stated above.		<b>22a. SIGNATURE</b> <b>Robert N. Coale</b> <b>M.D.</b> <b>22b. DATE SIGNED</b> <b>11/17/61</b> <b>22c. PHYSICIAN'S NAME (Type)</b> <b>ROBERT N. COALE</b> <b>22d. ADDRESS</b> <b>4429 BRADLEY LANE, CHEVY CHASE MD</b>	
<b>23a. BURIAL, CREMATION, 23b. DATE THEREOF</b> <b>Removal (Specify)</b> <b>11-20-61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Forest Home Cemetery</b> <b>23d. LOCATION (City, town or county)</b> <b>Forest Park, Illinois</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>ROBERT A. PUMPHREY</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE NOV 22 '61</b> <b>25b. REGISTRAR'S SIGNATURE</b>	



12803

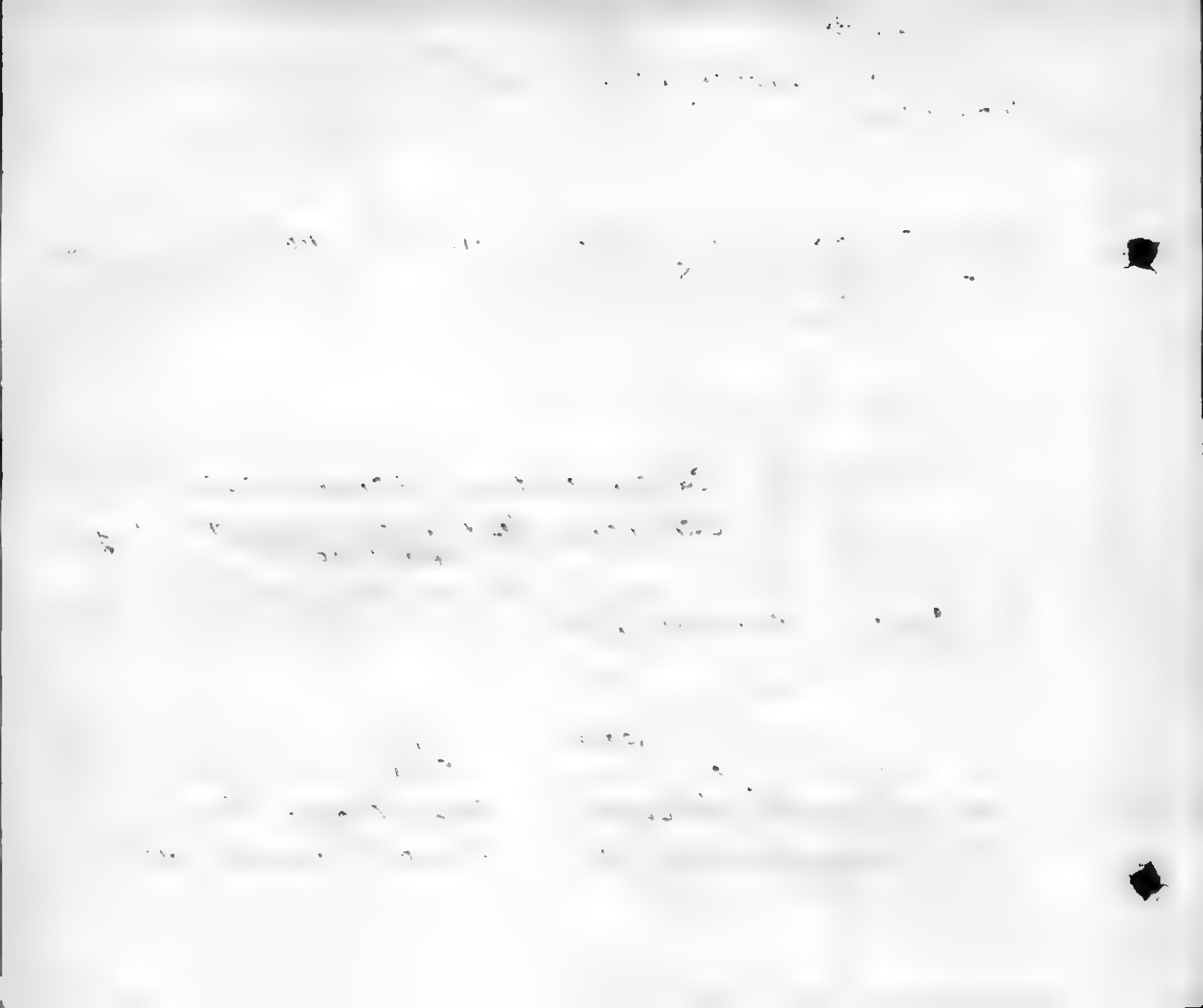
## CERTIFICATE OF DEATH

Reg. Dist. No. 2790

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
c. LENGTH OF STAY IN 1b <u>5 1/2 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>39 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____		d. STREET ADDRESS <u>11813 August Dr.</u>	
3. NAME OF DECEASED (Type or print) <u>DESSIE</u> First <u>ELIZABETH</u> Middle <u>FRANK</u> Last		4. DATE OF DEATH <u>NOVEMBER 5</u> 19 <u>61</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 11, 1884</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William B. Bowie</u>		14. MOTHER'S MAIDEN NAME <u>Cenia A. Davis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>—</u>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinomatosis, generalized</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>170X</u> DUE TO <u>Carcinoma, left breast - post operative</u>			
(c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anemia, secondary, severe</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>1958</u> , 19____, to <u>11-5-</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>11-5-</u> , 19 <u>61</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Samuel A. Hillman</u> M.D.		ADDRESS (Street, city or town, state) <u>8829 Flower Ave</u>	
PHYSICIAN'S NAME (Type) <u>SAMUEL A. HILLMAN</u>		DATE SIGNED <u>SILVER SPRING, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>Nov 8, 1961</u>	22c. NAME OF CEMETERY OR CREMATORIUM <u>FORT LINCOLN</u>	22d. LOCATION (City, town, or county) (State) <u>COLMAR MANOR, MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W W Talbot</u> ADDRESS <u>3603 14th St NW</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 7 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Wm D. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No. 12791

12804

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ednor</b>				c. LENGTH OF STAY IN lb <b>X</b> <b>Rockville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Belmont Nursing Home</b>				d. STREET ADDRESS <b>None</b>			
3. NAME OF DECEASED (Type or print) First <b>Marie</b> Middle <b>A</b> Last <b>Gardiner</b>				4. DATE OF DEATH Month <b>November</b> Day <b>14</b> Year <b>19 61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 4, 1869</b>	
9. AGE (In years last birthday) <b>92</b> yrs.		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>10</b>		11. IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>George W. Bowlen</b>				14. MOTHER'S MAIDEN NAME <b>Edmonia Candler</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
INFORMANT <b>7902 Kreeger Dr.</b> Address <b>Mrs. Buttell-daughter-Adelphi, Md.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Cerebral Thrombosis</b> DUE TO (c) <b>atherosclerosis, sen'iled</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b> <b>1 month</b> <b>sev'l yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>2/16/61</b> to <b>11/14/61</b> , that I last saw the deceased alive on <b>11/11/61</b> , and that death occurred at <b>3 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Donald Nelson</b>				ADDRESS (Street, city or town, state) <b>10620 Georgia Ave, S.E., Md 11/14/61</b>			
DATE SIGNED							
PHYSICIAN'S NAME (Type) <b>10620 Donald Nelson</b>				10620 Georgia Ave. Silver Spring Md			
22a. BURIAL, CREMAT ON, REMOVA (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/16/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Marys Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Barnesville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 16 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Oliver S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 42 hours after death.

VR AIS (4)  
15M 7/61

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

Item 220, Film 644, 1/10/61, iwk

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN 1b <u>10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Falls Church</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>1624 Hickory Hill Road</u> d. STREET ADDRESS <u>1624 Hickory Hill Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Minnie</u> Middle <u>Mae</u> Last <u>Getts</u>		4. DATE OF DEATH Month <u>November</u> Day <u>1</u> Year <u>19 61</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 23, 1907</u>
9. AGE (In years last birthday) <u>54</u> yrs		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Marshall Ward</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Mercer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>HUSBAND: Robert H. Getts, same as 12</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the uterus</u> 180X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) [County] [State]	
21. I certify that (H) (this hospital) attended the deceased from <u>October 23, 1961</u> to <u>November 1, 1961</u> that (X) (we) last saw the deceased alive on <u>November 1, 1961</u> , and that death occurred at <u>11:55 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>William P. Urshel</u> M.D.		22b. DATE SIGNED <u>November 2, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM P. URSHEL LT MC USN</u>		22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/6/1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City, town or county) [State] <u>Arlington, Virginia</u>	
24. GENERAL DIRECTOR'S SIGNATURE <u>Mac S. Morris</u>		25a. REC'D BY REGISTRAR <u>  </u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	
ADDRESS <u>301 N. Fairfax Dr., Arlington</u>		DATE <u>NOV 6 '61</u>	

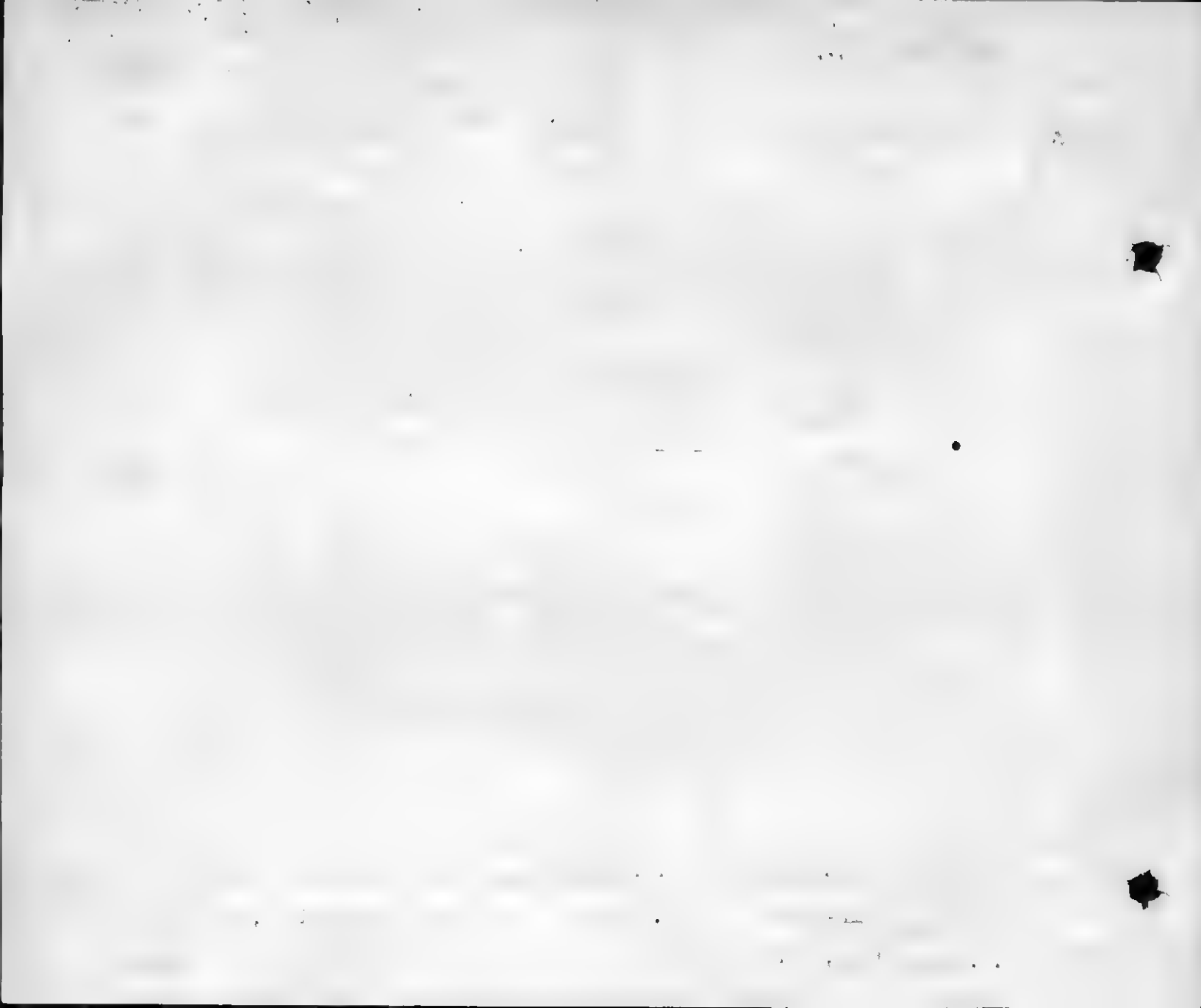


TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
FOR STATE  
HEALTH DEPT.

VS. A15ME  
SM 9/60

MAYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
12806											
12793											
1. PLACE OF DEATH a. COUNTY Montgomery						2. USUAL RESIDENCE (Where deceased lived, if inst lution; Residence before adm ssion) a. STATE Maryland					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park						b. COUNTY Montgomery					
c. LENGTH OF STAY IN 1b 2 1/2 days						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium and Hospital						d. STREET ADDRESS 638 Ritchie Avenue					
3. NAME OF DECEASED (Type or print) Louis WILLIAM LOUIS						4. DATE OF DEATH Month 11/21/61 Day 19 Year 19					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/9/97		9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unemployed				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Gibson						14. MOTHER'S MAIDEN NAME Eleanor Barrett					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service) No						16. SOCIAL SECURITY NO. 579-03-1709					
17. INFORMANT Hospital records						Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL INFARCTION, RT. OCCIPITAL DUE TO (b) PULMONARY AND CEREBRAL EDEMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DUODENAL ULCER WITH HEMORRHAGE											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Frank J. Broschart						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) Frank J. Broschart, M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED 11/21/61					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial						22b. DATE THEREOF 11-24-61					
22c. NAME OF CEMETERY OR CREMATORY St. Louis						22d. LOCATION (City, town, or country) (State) Clarksville, Md					
23. FUNERAL DIRECTOR F.C. Higinbotham, Ellicott City, Md						24a. REC'D BY REGISTRAR DATE NOV 24 '61					
						24b. REGISTRAR'S SIGNATURE Arthur L. Hume					



12807

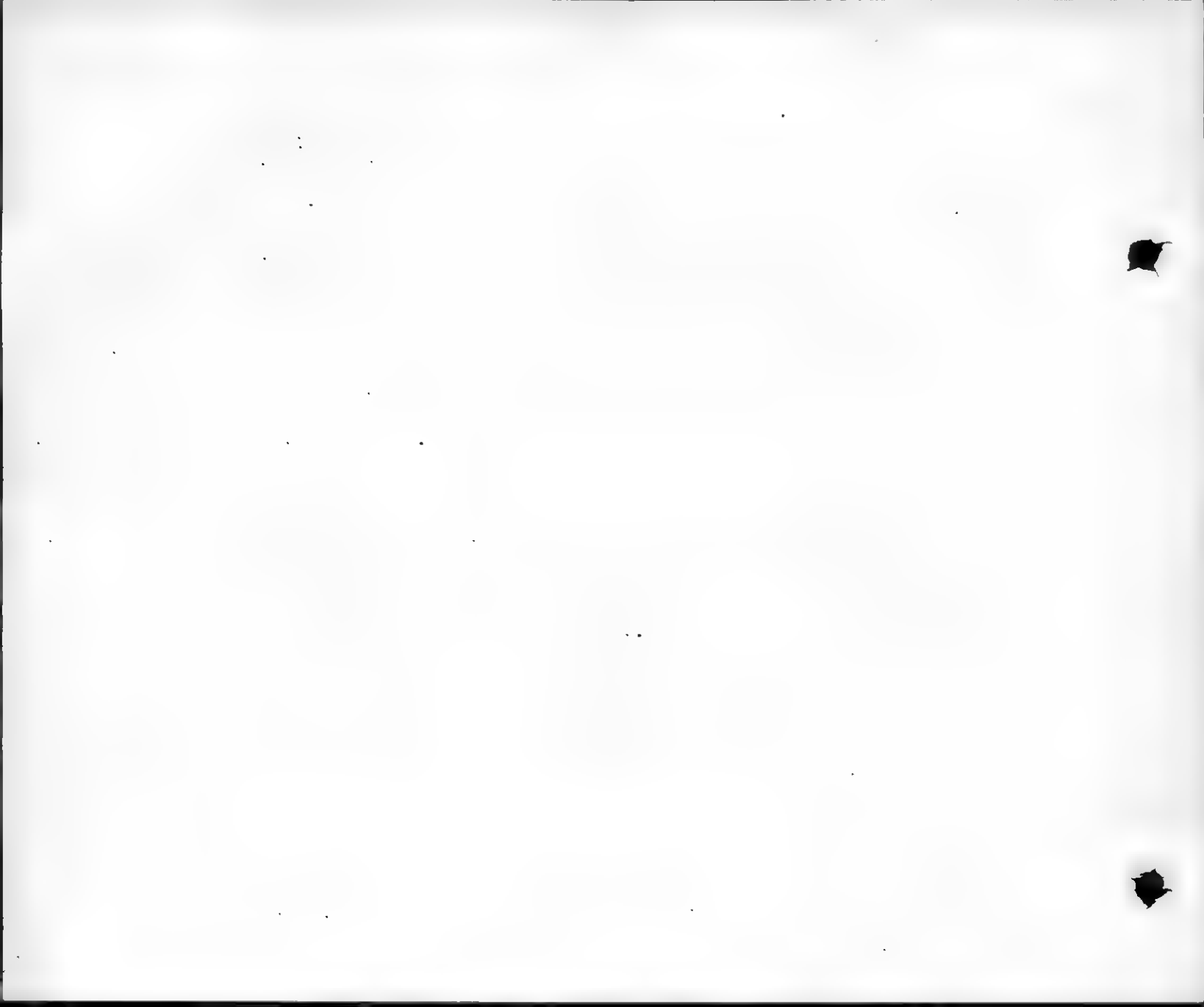
## CERTIFICATE OF DEATH

Reg. Dist. No. 12794

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>30 Silver Spring Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON SANITARIUM &amp; HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JENNIE</u> <u>GILBERT</u>		4. DATE OF DEATH Month Day Year <u>NOVEMBER</u> <u>27</u> <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 20 - 1895</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>POLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>KOPPEL DZIK</u>		14. MOTHER'S MAIDEN NAME <u>BELLA STAWICKY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>—</u>	
17. INFORMANT <u>DANIEL GILBERT</u>		Address <u>9501-DALLAS AVE, SS-MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Failure</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause ast. (b) <u>Myocardial degeneration</u> DUE TO (c) <u>Unknown</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of Thymus</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 29</u> , 19 <u>61</u> , to <u>Nov 27</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Nov 26</u> , 19 <u>61</u> , and that death occurred at <u>3:10</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Raymond O West</u> M.D.		DATE SIGNED <u>Nov 27/61</u>	
PHYSICIAN'S NAME (Type) <u>RAYMOND O. WEST, M.D.</u> <u>7600-CARROLL AVE. TAK. PK. MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>NOV 28-1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>NATIONAL CAPITAL HEB. CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>WASHINGTON D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>BERNARD DANZANSKY &amp; SONS - 3501-14th St.</u>		24. REC'D BY REGISTRAR <u>N.W.</u> DATE <u>NOV 29 '61</u>	24b. REGISTRAR'S SIGNATURE <u>William S. Thoms</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

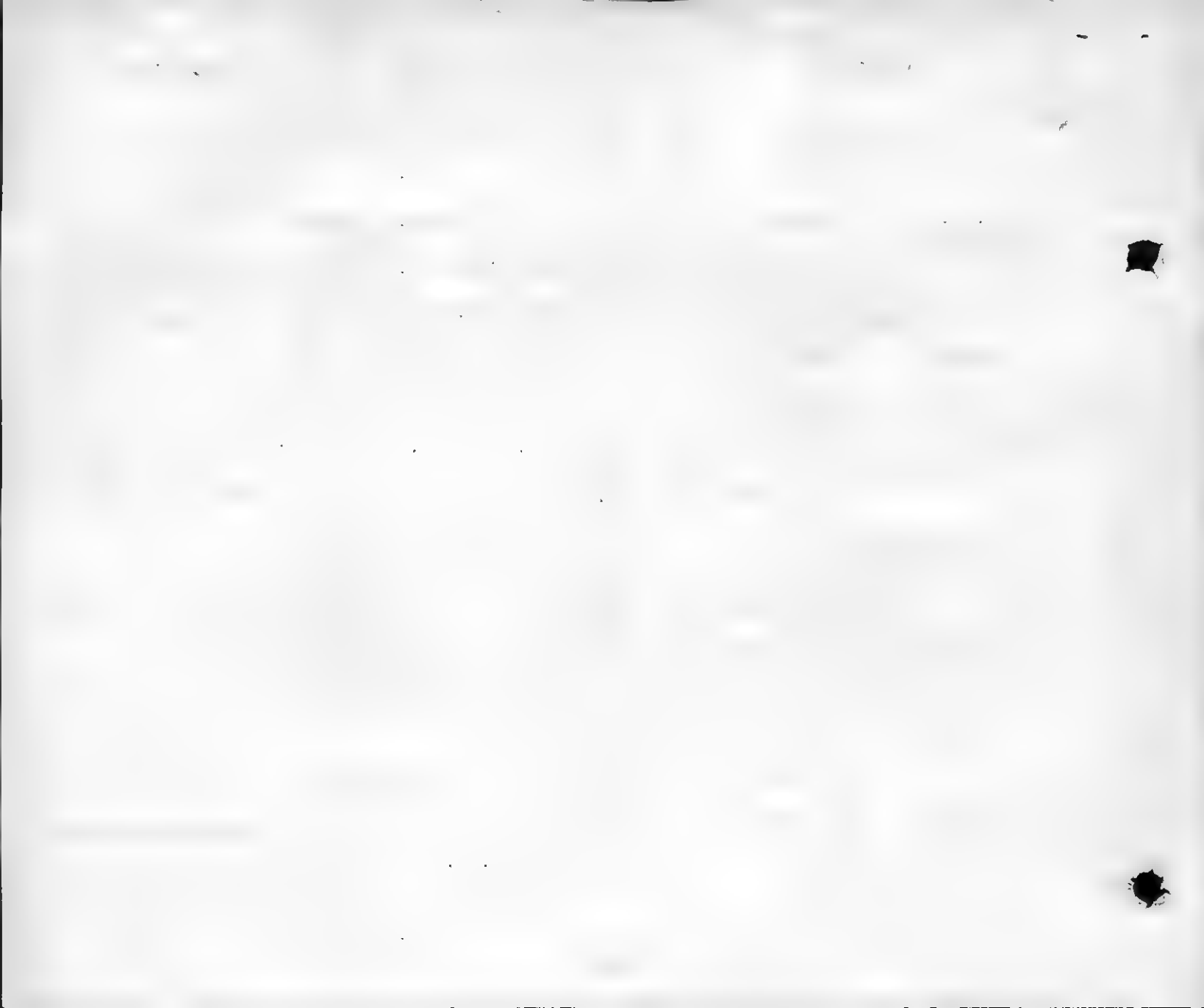
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12808

## CERTIFICATE OF DEATH

12791

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN 1b <u>191 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Naval Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Iowa</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Keokuk</u> d. STREET ADDRESS <u>701 Franklin Street</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Earl Eugene Gildersleeve</u>		<b>4. DATE OF DEATH</b> Month <u>November</u> Day <u>8</u> Year <u>1961</u>	
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>Caucasian</u>	
<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>March 19, 1897</u>	
<b>9. AGE</b> (In years last birthday) <u>64</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months _____ Days _____ Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Foreign Service Officer Diplomat</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Iowa</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>William Homer Gildersleeve</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Anna State</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW I</u>		<b>16. SOCIAL SECURITY NO.</b> <u>347 09 9496</u>	
<b>17. INFORMANT</b> <u>WIFE: Ellia L. Gildersleeve, Same as #2</u>		<b>Address</b> _____	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic Adenocarcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO _____ DUE TO _____			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)	
<b>20c. TIME OF INJURY</b> Month, Day, Year _____ Hour a.m. _____ p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____		<b>20f. (City or town)</b> _____ (County) _____ (State) _____	
<b>21. I certify that</b> (X (this hospital) attended the deceased from <u>May 2, 1961</u> to <u>November 8, 1961</u> , that (X (we) last saw the deceased alive on <u>November 8, 1961</u> , and that death occurred at <u>11:20 PM</u> from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <u>Ernie H. H. M.D.</u>		<b>22b. DATE SIGNED</b> <u>November 9, 1961</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) _____		<b>22d. ADDRESS</b> <u>U. S. Naval Hospital, Bethesda, Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>11-14-61</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> _____		<b>23d. LOCATION</b> (City, town or county) <u>Keokuk, Iowa</u> (State) _____	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Pumphrey</u>		<b>25a. REC'D BY REGISTRAR</b> <u>NOV 15 '61</u>	
<b>ADDRESS</b> <u>Robert A. Pumphrey, Bethesda, Maryland</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hume</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12803

12796

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San. &amp; Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs, Md.</u> d. STREET ADDRESS <u>#6 Normandy Dr.</u>													
<b>3. NAME OF</b> (Type or print) <u>Dora</u>		<b>4. DATE OF DEATH</b> Month <u>11</u> Day <u>1</u> Year <u>1961</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>													
<b>8. DATE OF BIRTH</b> <u>10-27-78</u>		<b>9. AGE</b> (In years last birthday) <u>83</u> yrs. <table border="1" style="display: inline-table; vertical-align: top;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS</td> </tr> <tr> <td>Months <u>8</u> Days <u>3</u></td> <td>Hours <u>1</u> M. <u>1</u></td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS	Months <u>8</u> Days <u>3</u>	Hours <u>1</u> M. <u>1</u>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>									
IF UNDER 1 YEAR	IF UNDER 24 HRS																
Months <u>8</u> Days <u>3</u>	Hours <u>1</u> M. <u>1</u>																
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>House wife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>At Home</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>D.C.</u>													
<b>13. FATHER'S NAME</b> <u>James F. Simmons</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Martha Benton</u>															
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war and dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>none</u>		<b>17. INFORMANT</b> <u>Washington San &amp; Hosp. Records</u>													
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) <table border="1" style="width: 100%;"> <tr> <td colspan="2"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b>  <u>420.0</u> DUE TO  <u>Arteriosclerotic Heart Disease with heart failure</u> </td> <td rowspan="3" style="vertical-align: top;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <u>12 hours</u>   <u>7 days</u> </td> </tr> <tr> <td colspan="2"> <b>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>  <b>(b)</b>  <u>Arteriosclerotic Heart Disease</u> </td> </tr> <tr> <td colspan="2"> <b>(c)</b>  <u>Arteriosclerotic Heart Disease</u> </td> </tr> <tr> <td colspan="3"> <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> </td> <td colspan="2" style="vertical-align: top;"> <b>19. WAS AUTOPSY PERFORMED?</b>                  YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> </td> </tr> </table>						<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>420.0</u> DUE TO <u>Arteriosclerotic Heart Disease with heart failure</u>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>12 hours</u>  <u>7 days</u>	<b>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>(b)</b> <u>Arteriosclerotic Heart Disease</u>		<b>(c)</b> <u>Arteriosclerotic Heart Disease</u>		<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>			<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>420.0</u> DUE TO <u>Arteriosclerotic Heart Disease with heart failure</u>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>12 hours</u>  <u>7 days</u>															
<b>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>(b)</b> <u>Arteriosclerotic Heart Disease</u>																	
<b>(c)</b> <u>Arteriosclerotic Heart Disease</u>																	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>			<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>																	
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)																	
<b>20c. TIME OF INJURY</b> Hour a.m. <u>19</u> p.m.		<b>20d. INJURY OCCURRED</b> White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)													
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>													
<b>21. I certify that (I) (this hospital) attended the deceased from <u>10/23</u>, 19<u>61</u>, to <u>11/1</u>, 19<u>61</u>, that (I) (<u>we</u>) last saw the deceased alive on <u>11/1</u>, 19<u>61</u>, and that death occurred at <u>7:25 AM</u>, from the causes and on the date stated above.</b>																	
<b>22a. SIGNATURE</b> <u>HUGH W. IREY</u>		<b>22b. DATE SIGNED</b> <u>11/1/61</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>HUGH W. IREY</u>													
<b>22d. ADDRESS</b> <u>7105 - Riggs Rd., Hyattsville, Md.</u>		<b>22e. ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>															
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>11-6-1961</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Rock Creek Cem</u>													
<b>23d. LOCATION</b> (City, town or county) <u>Washington D.C.</u>		<b>23e. REC'D BY REGISTRAR</b>															
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>W.W. Chambers Inc.</u>		<b>24b. ADDRESS</b> <u>Silver Spring, Md.</u>		<b>25. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>													
<b>DATE</b> <u>NOV 6 '61</u>																	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

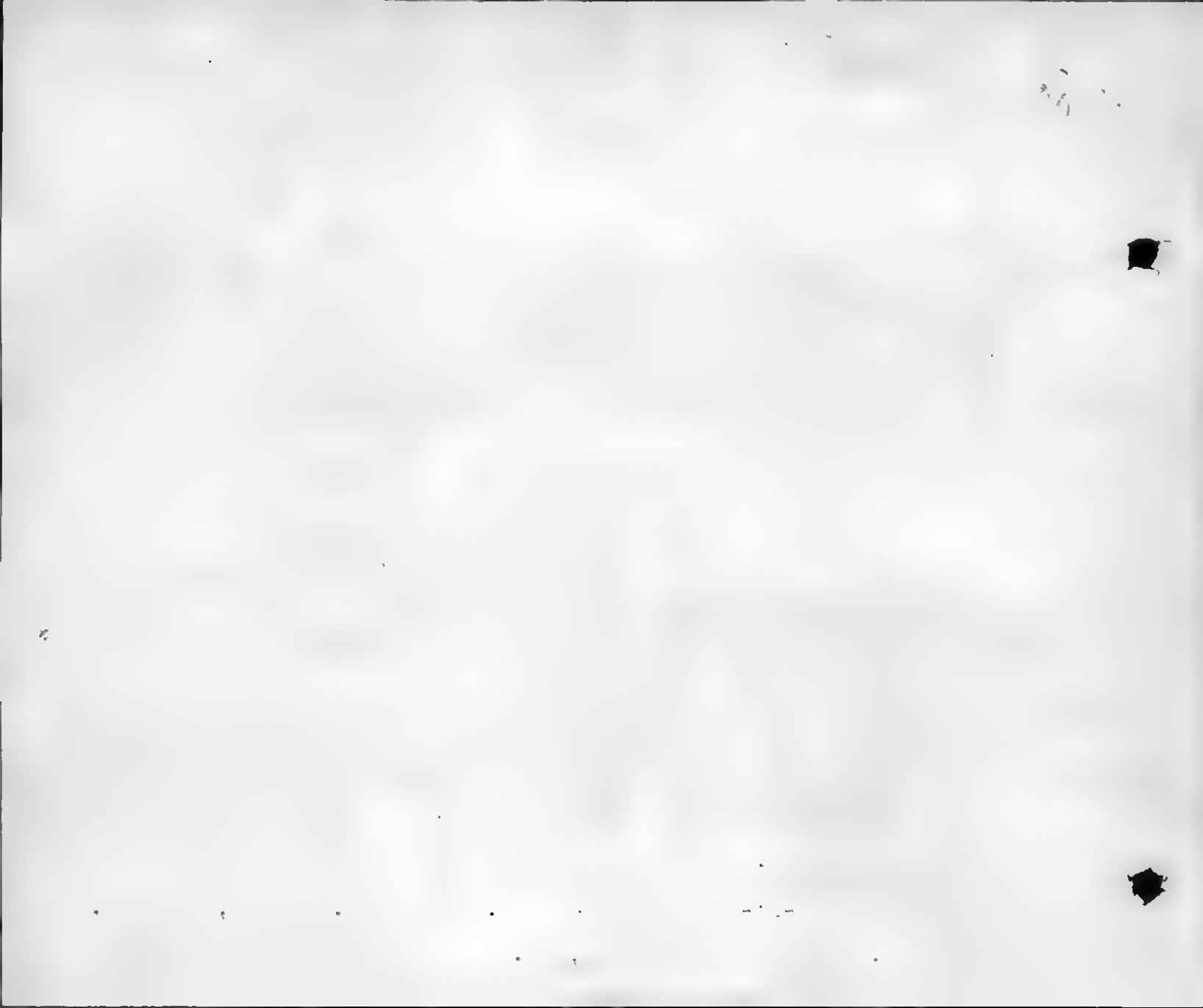
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12810

12797

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> c. LENGTH OF STAY IN 1b <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>W. H. Son &amp; Co.</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> d. STREET ADDRESS <u>31 Parkside Drive</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Anna</u> First <u>Francis</u> Middle <u>Geoff</u> Last <u>Geoff</u>		<b>4. DATE OF DEATH</b> Month <u>11</u> Day <u>12</u> Year <u>1961</u>	
<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>3-8-04</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u>		<b>11. BIRTHPLACE</b> (County & State or foreign country) <u>Conn.</u>	
<b>13. FATHER'S NAME</b> <u>Charles</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Ann</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>17. INFORMANT</b> <u>W. H. Son &amp; Co.</u> Address <u>Frederick</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>SOOX</u> DUE TO <u>Arricular fibrillation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Congestive heart failure</u> DUE TO <u>Acute bronchitis + pneumonia viral</u>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>3-4 days</u> <u>3-4 weeks</u> <u>3-4 days</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>Tuberculosis - left thoracoplasty 1940</u>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>008X</u>		<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u> <b>20f. (City or town)</b> (County) (State) <u>Frederick</u>	
<b>21. I certify that (i) (this hospital) attended the deceased from</b> <u>11-6-1961</u> <b>to</b> <u>11-12-1961</u> , <b>that (i) (we) last saw the deceased alive on</b> <u>11-12-1961</u> , <b>and that death occurred at</b> <u>4 P.M.</u> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Charles R. Shultz, MD</u> <b>22b. DATE SIGNED</b> <u>11-12-61</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>CHARLES R. SHULTZ</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial-transit 11-13-61</u>		<b>23b. DATE THEREOF</b> <u>11-13-61</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Cunningham Mem. Park</u>		<b>23d. LOCATION (City, town or county)</b> <u>St. Albans, West Va.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>ROBERT A. PUMPHREY</u> <b>ADDRESS</b> <u>Bethesda, Md.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>NOV 16 '61</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>	



## CERTIFICATE OF DEATH

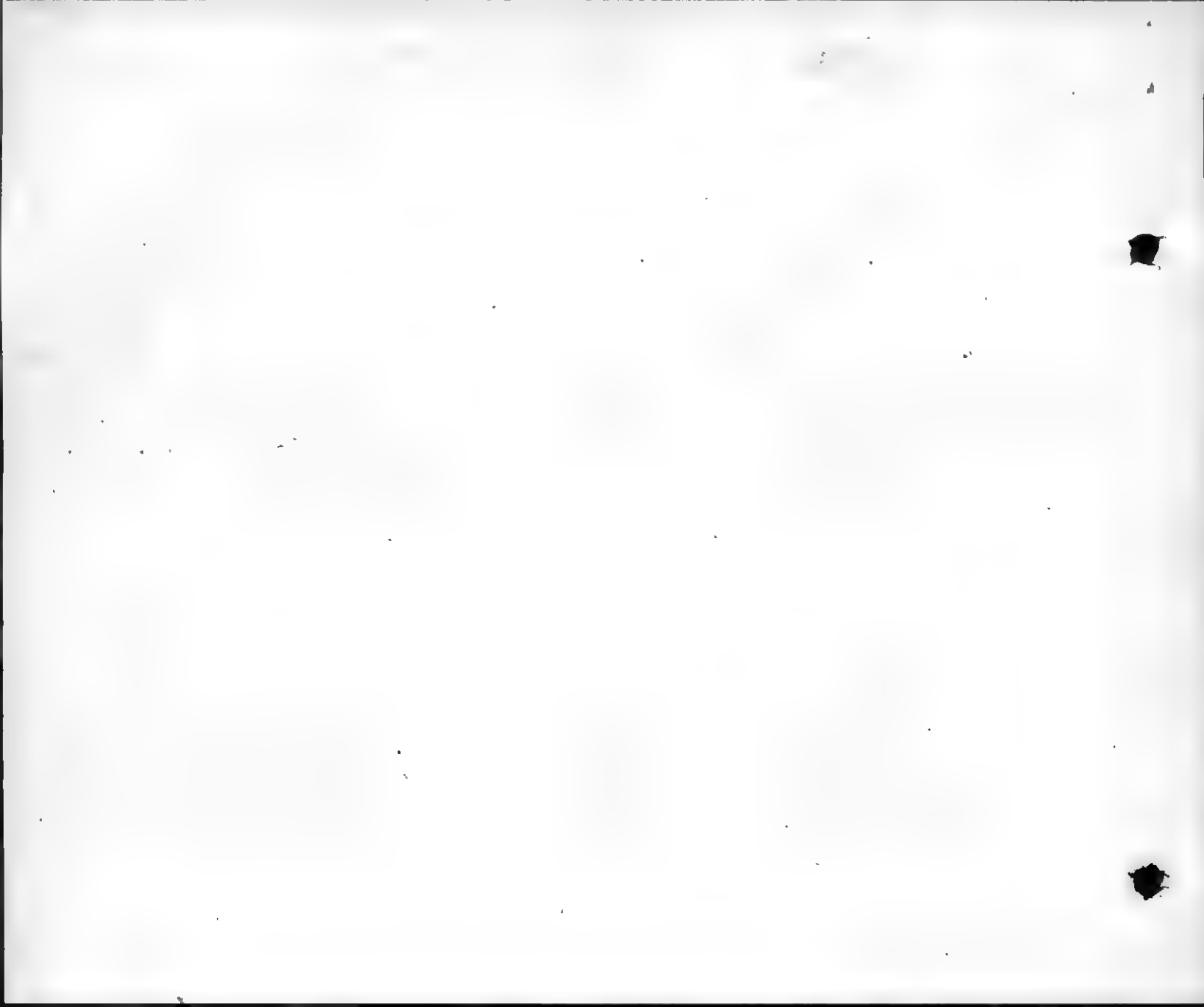
Reg. Dist. 12798

12811

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA 48</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4800 CHEVY CHASE DRIVE</b>		d. STREET ADDRESS <b>4800 CHEVY CHASE DRIVE</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>DR. MAURICE A. GOLDBERG</b>		4. DATE OF DEATH Month Day Year <b>Nov. 8, 1961 19</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 29, 1904</b>
9. AGE (In years lost birthday) <b>57</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DENTIST</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MINNESOTA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>SAMUEL GOLDBERG</b>		14. MOTHER'S MAIDEN NAME <b>ESTHER BELLE WILNER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>578-44-1695</b>	
17. INFORMANT <b>MRS. RUTH M. GOLDBERG</b>		Address <b>4800 Chevy Chase Dr., Bethl., Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) _____ Conditions if any, which gave rise to immediate cause (c), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>14 MED</b> <b>Years.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1942</b> to <b>11/8</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>11/6</b> , 19 <b>61</b> , and that death occurred at <b>5:10 P.</b> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Paul D. Cantor</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>4709 Montgomery Lane, Beth., Md.</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Paul D. Cantor</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-10-61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bernard Danzansky &amp; Sons</b>		24a. REC'D BY REGISTRAR <b>NOV 13 '61</b>	
ADDRESS <b>3501 14th St. NW</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12812

CERTIFICATE OF DEATH

Ref. 12812

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring Md.</u>		c. LENGTH OF STAY IN 1b <u>4 WEEKS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Del Pre Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Frank Henry Greatorex</u>		4. DATE OF DEATH <u>November 24 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 3, 1892</u>
9. AGE (In years lost birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard - RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C. GOV'T.</u>	
11. BIRTHPLACE (State or foreign country) <u>Shelton, Conn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>WILLIAM GREATOREX</u>		14. MOTHER'S MAIDEN NAME <u>MARY ROBINSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>578-14-0765</u>	
17. INFORMANT <u>JEAN T. KISSINGER</u>		Address <u>SAME AS #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1 Congestive Heart Failure</u> DUE TO (b) <u>Coronary vascular disease</u> DUE TO (c) <u>Myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-24-61</u> , 19 <u>61</u> , to <u>Nov. 24, 1961</u> , that I last saw the deceased alive on <u>Nov. 24</u> , 19 <u>61</u> , and that death occurred at <u>9 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>M.D. 3701 Leland ST</u> DATE SIGNED <u>Nov 24 1961</u>			
ACTUAL SIGNATURE <u>J. R. Reedy</u>		PHYSICIAN'S NAME (Type) <u>Clery Chase M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-28-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Elizabeth Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Reedy</u>		ADDRESS <u>3821-145th Ave, D.C.</u>	
24a. REC'D BY REGISTRAR <u>Nov 27 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Clery Chase</u>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

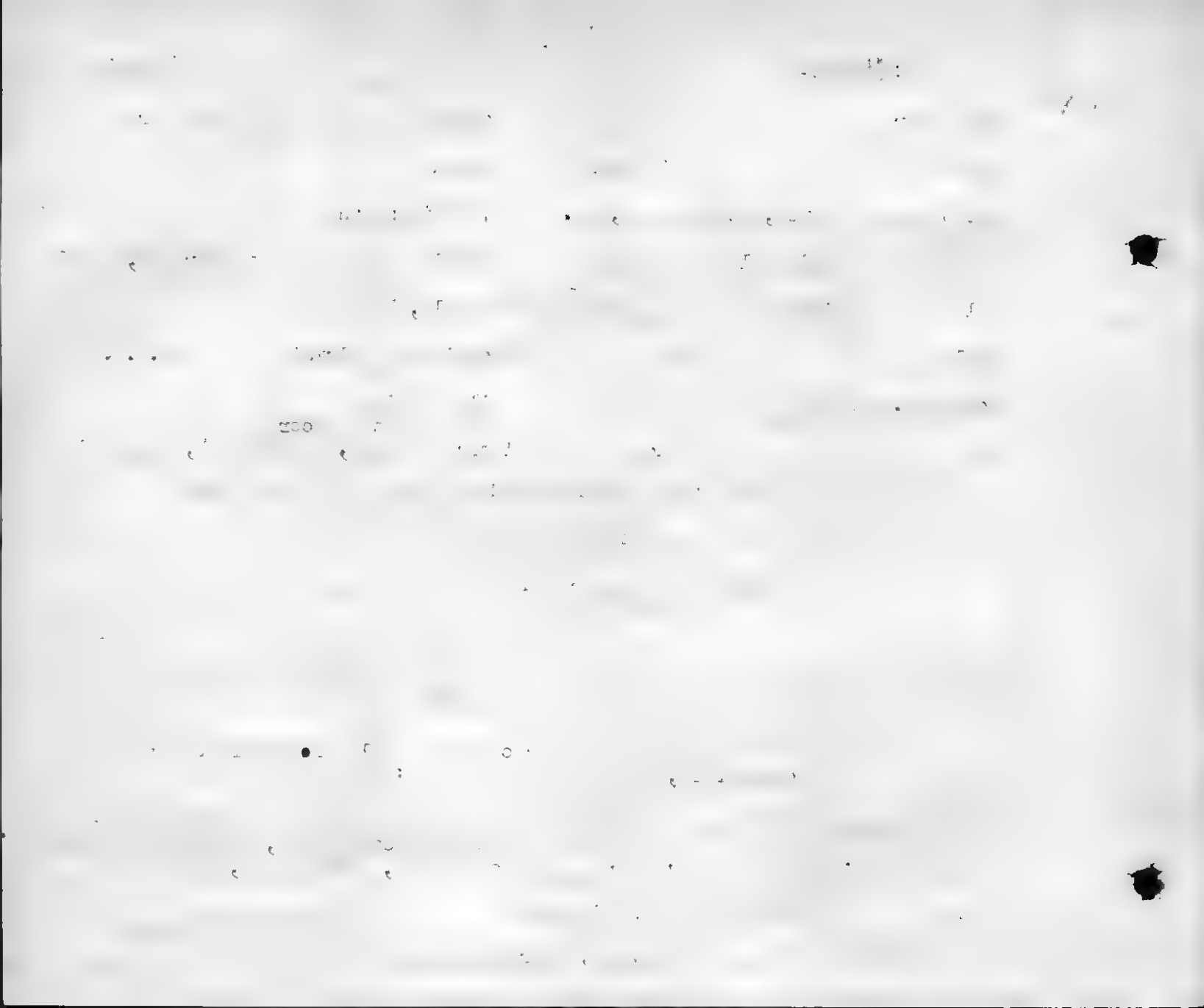
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12813

12860

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>33 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Lanham</b> d. STREET ADDRESS <b>7706 Finns Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Michael Robert Griffin</b>		4. DATE OF DEATH Month <b>November</b> Day <b>20</b> Year <b>19 61</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 13, 1956</b>	
9. AGE (in years last birthday) <b>5 yrs</b>		10. F UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>District of Columbia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert A. Griffin</b>		14. MOTHER'S MAIDEN NAME <b>Wilda Tusing</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMATION <b>The Medical Record</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Suppurative pneumonia with multiple abscess formation</b> DUE TO (b) <b>Gastrointestinal hemorrhage</b> DUE TO (c) <b>Acute lymphocytic leukemia</b> PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>204.2</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>9 days</b> <b>1 year</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> e.m. p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>October 18, 1961</b>		20g. (County) <b>November 20, 1961</b>	
20h. (State) <b>1:45AM</b>		21. I certify that (X) (this hospital) attended the deceased from <b>October 18, 1961</b> to <b>November 20, 1961</b> that (X) (we) last saw the deceased alive on <b>November 20, 1961</b> and that death occurred <b>1:45AM</b> from the causes and on the date stated above.	
22a. SIGNATURE <b>J. David Heywood</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>J. David Heywood, M.D.</b>		22b. DATE SIGNED <b>November 20-1961</b> 22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/22/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		23d. LOCATION (City, town or county) (State) <b>Colmar Manor, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis Gasch's Sons</b>		25. REC'D BY REGISTRAR <b>NOV 24 61</b>	
25a. ADDRESS <b>Hyattsville, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Smith</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

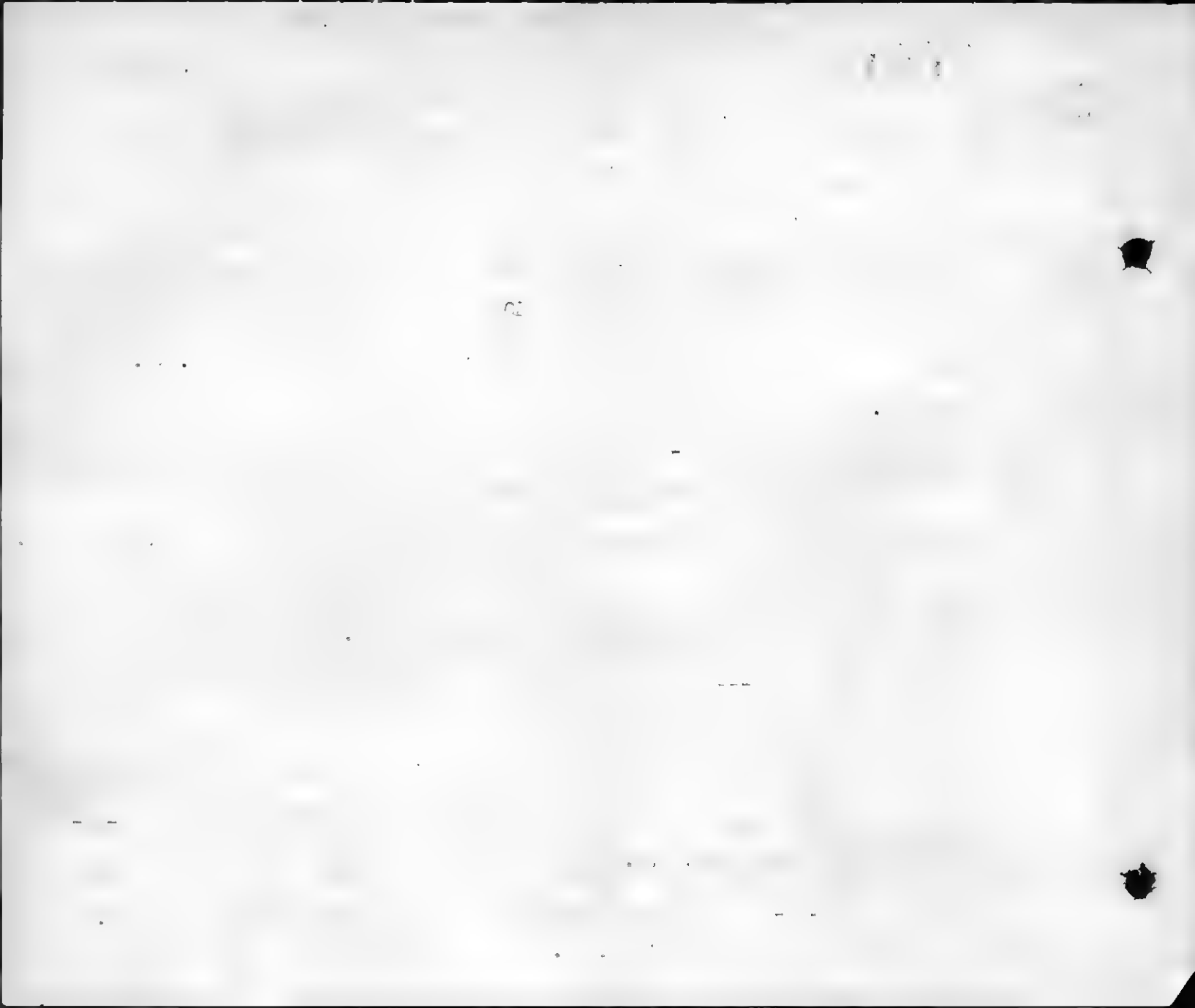
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12814

## CERTIFICATE OF DEATH

12801

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OLNEY</u> c. LENGTH OF STAY IN TB <u>1 hour</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MONTGOMERY GENERAL HOSPITAL</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GAITHERSBURG</u> d. STREET ADDRESS <u>Route 1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>GREENBERRY GAITHER GRIFFITH</u>		<b>4. DATE OF DEATH</b> Month <u>11</u> Day <u>22</u> Year <u>19 61</u>	
<b>5. SEX</b> <u>MALE</u>		<b>6. COLOR OR RACE</b> <u>WHITE</u>	
<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>4/10/74</u>		<b>9. AGE</b> (In years last birthday) <u>87</u> yrs.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Farmer</u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>MARYLAND</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>CHARLES H. GRIFFITH</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>HESTER DORSEY</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>-</u>	
<b>17. INFORMANT</b> <u>HOSPITAL RECORDS</u>		<b>Address</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>ACUTE CORONARY THROMBOSIS</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>ADENOCARCINOMA OF PROSTATE GLAND.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ADENOCARCINOMA OF PROSTATE GLAND.</u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <u>---</u>			
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part I of item 18) <u>---</u>		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>19</u> e.m. p.m.	
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>---</u>	
<b>20f. (City or town)</b> <u>---</u>		<b>(County)</b> <u>---</u>	
<b>(State)</b> <u>---</u>		<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>MAY 1960 to 11-22, 1961</u> , that (I) (we) last saw the deceased alive on <u>11-22, 1961</u> , and that death occurred at <u>8:55A</u> , from the causes and on the date stated above.	
<b>22a. SIGNATURE</b> <u>Jack Schumacher</u> M.D. <b>22b. PHYSICIAN'S NAME</b> (Type) <u>JACK SCHUMACHER, M.D.</u>		<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22d. ADDRESS</b> <u>GAITHERSBURG, MARYLAND</u>	
<b>22b. DATE SIGNED</b> <u>11-22-61</u>		<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	
<b>23b. DATE THEREOF</b> <u>11-25-61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Goshen Cemetery</u>	
<b>23d. LOCATION</b> (City, town or county) <u>Goshen, Montgomery, Md.</u>		<b>(State)</b> <u>---</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Francis X. Barber</u>		<b>ADDRESS</b> <u>Laytonsville, Md.</u>	
<b>25a. REC'D BY REGISTRAR</b> <u>NOV 29 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles L. Thomas</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12815

12802

Item 23b, Film G301, 11/29/61 iwk

Item 14-Film G302-11/29/61 iwk

### 1. PLACE OF DEATH

a. COUNTY

MONTGOMERY

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

BETHESDA (Rural)

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

U. S. NAVAL HOSPITAL

3. NAME OF DECEASED  
(Type or print)

First

FRANKLIN

Middle

LEON

Last

GROUT, III

5. SEX

MALE

6. COLOR OR RACE

CAUC.

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

NOVEMBER 24, 1941

9. AGE (In years last birthday)

20 yrs.

10. USJAL OCCUPATION (Give kind of work done during most of working life, even if retired)

U. S. NAVY

13. FATHER'S NAME

FRANKLIN LEON GROUT, JR.

14. MOTHER'S M A DEN NAME

ALVAH ELIZABETH LOOMIS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

YES

16. SOCIAL SECURITY NO.

066-32-6208

17. INFORMANT

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

Respiratory failure  
Carcinoma metastases

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY  
Hour e.m.  
p.m.

Month, Day, Year  
19

20d. INJURY OCCURRED  
While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that ~~20~~ (this hospital) attended the deceased from OCT. 27, 1961 to NOV. 23, 1961, that ~~we~~ (we) last saw the deceased alive on NOV. 23, 1961, and that death occurred at 4:55 PM on the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

W. F. WARRENDER LT MC USN

M.D.

ATTENDING PHYS. ☐

MED. DIRECTOR ☐

STAFF PHYS. ☒

22b. DATE SIGNED  
Nov. 24, 1961

22d. ADDRESS

U. S. NAVAL HOSPITAL, BETHESDA, MD.

23a. BURIAL, CREMATION REMOVAL (Specify)

Burial

23b. DATE THEREOF

Nov. 25, 1961

23c. NAME OF CEMETERY OR CREMATORY

White Chapel

23d. LOCATION (City, town or county)

Tonawanda, New York

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

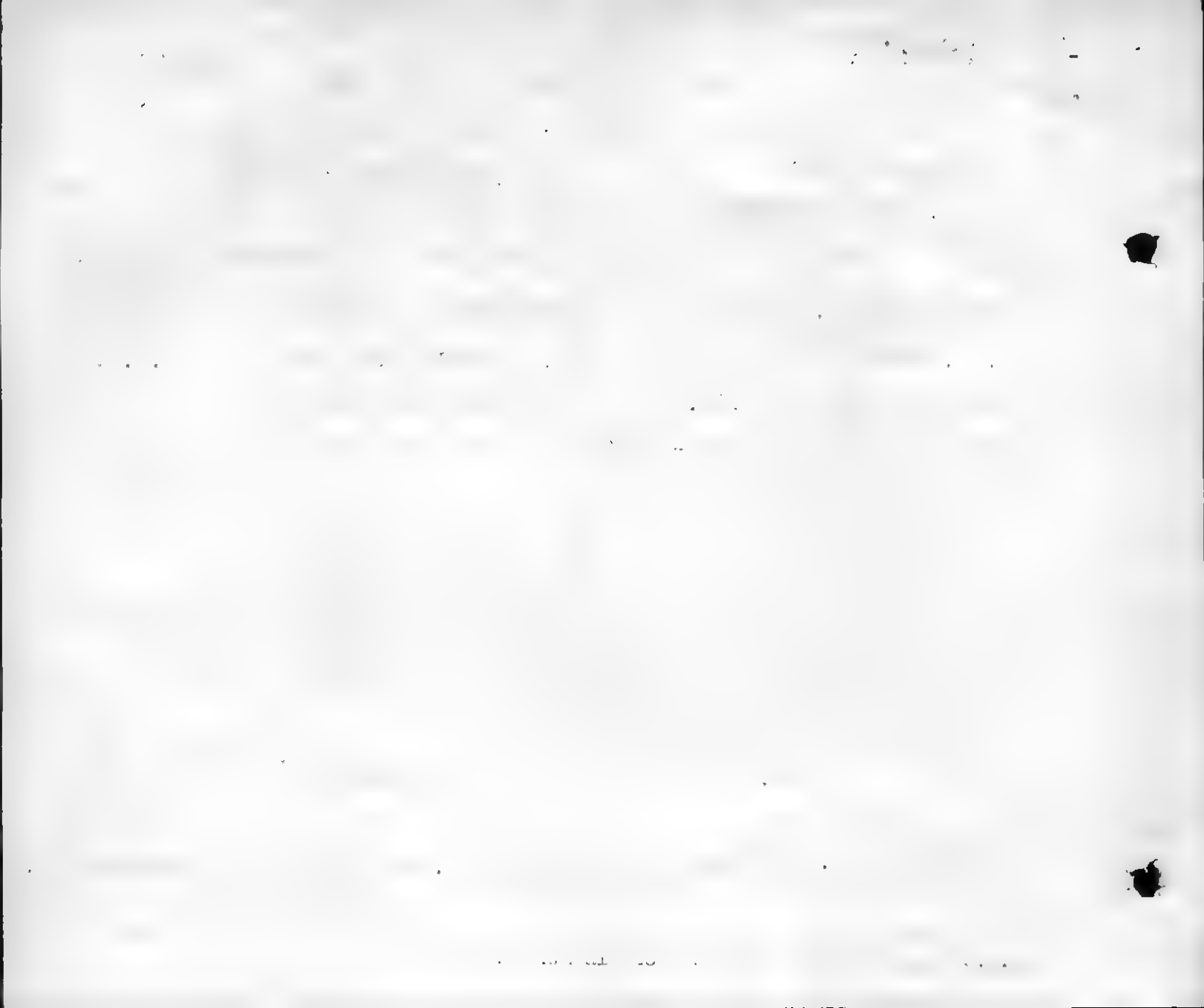
W.W. Chambers Funeral Home, 1400 Chapin St. NW, WDC

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DATE NOV 27 '61

Chambers



1

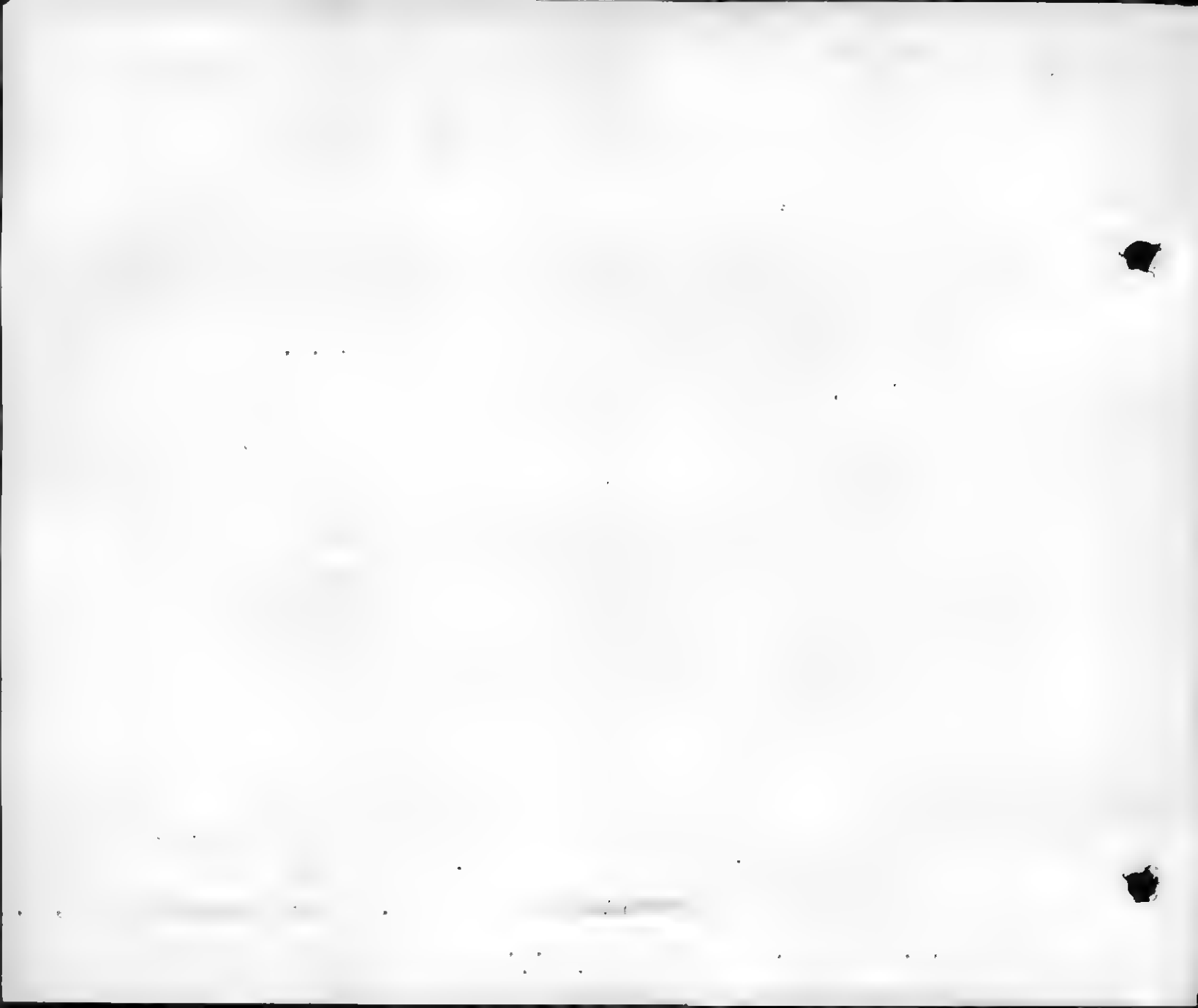
M

12816

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12802

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7216 Holly Avenue</b>				d. STREET ADDRESS <b>7216 Holly Avenue</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>ELIZABETH HOWARD GUERRY</b>				4. DATE OF DEATH Month Day Year <b>Nov 25 1961</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>15 OCT 1871</b>	9. AGE (in years last birthday) <b>90</b> yrs.	10. IF UNDER 1 YEAR: Months Days Hours Min.		11. IF UNDER 24 HRS: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Louie M. Smith</b>				14. MOTHER'S MAIDEN NAME <b>Franklin Catherine Beeler</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>no</b>		17. INFORMANT Address <b>Self (Pre-Arrangement)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>332X</b> DUE TO (b) <b>Cerebral Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>Arteriosclerosis Generalized</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>1 Nov 1960</b> to <b>25 Nov 1961</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>23 Nov 1961</b> , and that death occurred at <b>5 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Thomas P. Fogarty</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>25 Nov 61</b>			
22c. PHYSICIAN'S NAME (Type) <b>THOMAS P. FOGARTY</b>		22d. ADDRESS <b>1811 UNIV. BLVD EAST SILVER SPRING MD</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/28/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Crematory, Prince Georges County, Md.</b>		23d. LOCATION (City, town, or county) (State)			
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>The S.H. Hines Co. 2901 14th St. N.W. Washington 9, D.C.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 28 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Annopolis</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annopolis</u>	
c. LENGTH OF STAY IN 1b <u>66 days</u>		d. STREET ADDRESS <u>1 Taney Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital, Bethesda, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles Greham Halpine</u>		4. DATE OF DEATH <u>November 3, 1961</u>	
5 SEX <u>Male</u> 6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>April 22, 1893</u>	
8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (in years last birthday) <u>68 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Naval Officer</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Nicholas Halpine</u>		14. MOTHER'S MAIDEN NAME <u>Alice Macomb</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes WWI</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>WIFE: Mrs. Helen B. Halpine, same as #2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Emboli</u> DUE TO (b) <u>Pneumonia</u> DUE TO (c) <u>Metastatic Carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>3 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u>None</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>10</u> (this hospital) attended the deceased from <u>August 30, 1961</u> , to <u>November 3, 1961</u> , that <u>10</u> (we) last saw the deceased alive on <u>November 3, 1961</u> , and that death occurred at <u>6:30 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>William P. Baker</u> M.D.		22b. DATE SIGNED <u>November 3, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM P. BAKER LT MC USN</u>		22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-7-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Naval Academy Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Annopolis, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN M. TAYLOR</u> ADDRESS <u>1444 Lancaster St., Annopolis</u> Md.		25a. REC'D BY REGISTRAR <u>NOV 6 1961</u> 25b. REGISTRAR'S SIGNATURE <u>John M. Taylor</u>	



## CERTIFICATE OF DEATH

Reg. Dist. 12805

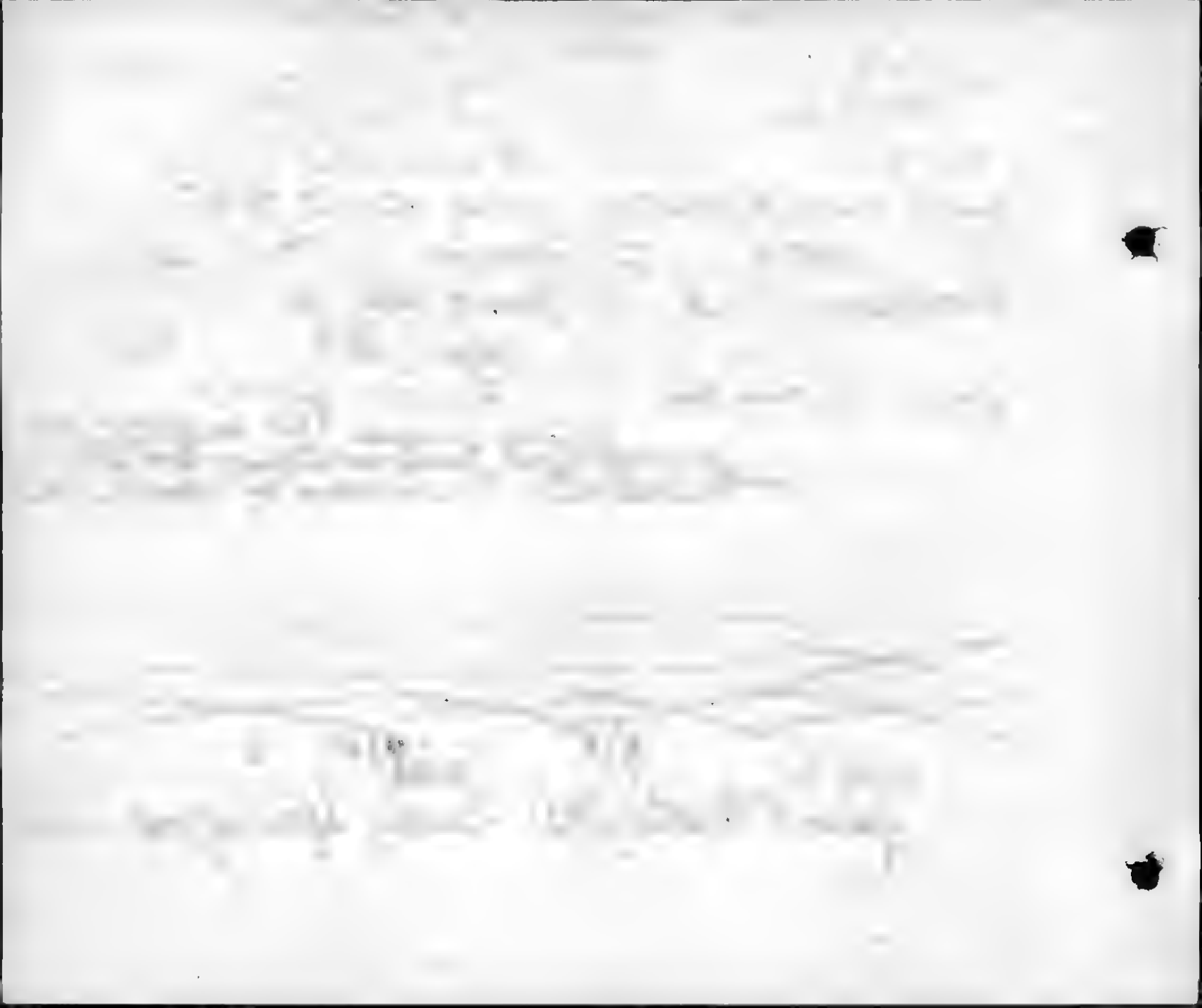
12819

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <i>DC</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Olney</i>		c. LENGTH OF STAY IN 1b <i>3rd</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Brooke Grove Foundation</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i> <i>41A 3</i>	
f. STREET ADDRESS <i>5923 4TH ST. N.W.</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Katie</i> Middle <i>I.</i> Last <i>Hancock</i>		4. DATE OF DEATH Month <i>Nov.</i> Day <i>20</i> Year <i>1961</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>conc</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 19 1883</i>
9. AGE (In years last birthday) <i>78</i> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Wash DC</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>	
13. FATHER'S NAME <i>Harry Hunnaker</i>		14. MOTHER'S MAIDEN NAME <i>Louise Jones</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>3923 4TH ST N.W. DC</i>	
17. INFORMANT <i>Harry Hancock</i>		Address	
18. CAUSE OF DEATH (Enter only one cause for Part I, II, and III) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <i>153.8 Metastatic carcinoma of colon (2nd)</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>9/14</i> , 19 <i>61</i> , to <i>11/20</i> , 19 <i>61</i> , that I last saw the deceased alive on <i>11/16/61</i> , 19 <i>61</i> , and that death occurred at <i>6:15 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>John P. Martin, MD</i> <i>Sandy Springs, Md</i> <i>11/20/61</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11-22-61</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Suitland Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Beat Thomas of Home</i>		ADDRESS <i>4814 G.A. Ave N.W.</i>	
24a. REC'D BY REGISTRAR DATE <i>NOV 21 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Robert S. Thomas</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12820

Item 8 Film G-02 12/13/61 iwk

12806

### 1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Germantown

c. LENGTH OF STAY in 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Montgomery General Hospital

### 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

Maryland

b. COUNTY

Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X Germantown

d. STREET ADDRESS

Rt. #1

e. IS RESIDENCE ON A FARM?  
YES ☐ NO ☒

### 3. NAME OF DECEASED (Type or print)

Robert

Donald

Harding

5 SEX

Male

6 COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

Oct. 14, 1891 1893

9. AGE (In years last birthday)

68 yrs

10. UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Atomic Energy Comm.

10b. KIND OF BUSINESS OR INDUSTRY

Government

11. BIRTHPLACE (County & State, or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Zacharias Harding

14. MOTHER'S MAIDEN NAME

Grace Hodgson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Hospital Records

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

SUBARACHNOID HEMORRHAGE, EXTENSIVE.

330X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

RUPTURED ANEURYSM CEREBRAL ARTERY.

DUE TO

Arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (e)

INTERVAL BETWEEN ONSET AND DEATH

2 days

2 days

Feas

19. WAS AUTOPSY PERFORMED?  
YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY  
Hour a.m.  
p.m.

Month, Day, Year  
19

20d. INJURY OCCURRED  
While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Nov. 27, 1961 to Dec. 29, 1961, that (I) (we) last saw the deceased alive on Nov. 24, 1961, and that death occurred at 10:29 P.M. from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

JACK SCHUMACHER, M.D.

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS. ☐

22b. DATE SIGNED

22d. ADDRESS

GAITHERSBURG, MARYLAND

23a. BURIAL, CREMATION, 23b. DATE THEREOF  
REMOVAL (Specify)

Burial 11-2-61

23c. NAME OF CEMETERY OR CREMATORY

Forest Oak

23d. LOCATION (City, town or county)

Gaithersburg, Md.

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

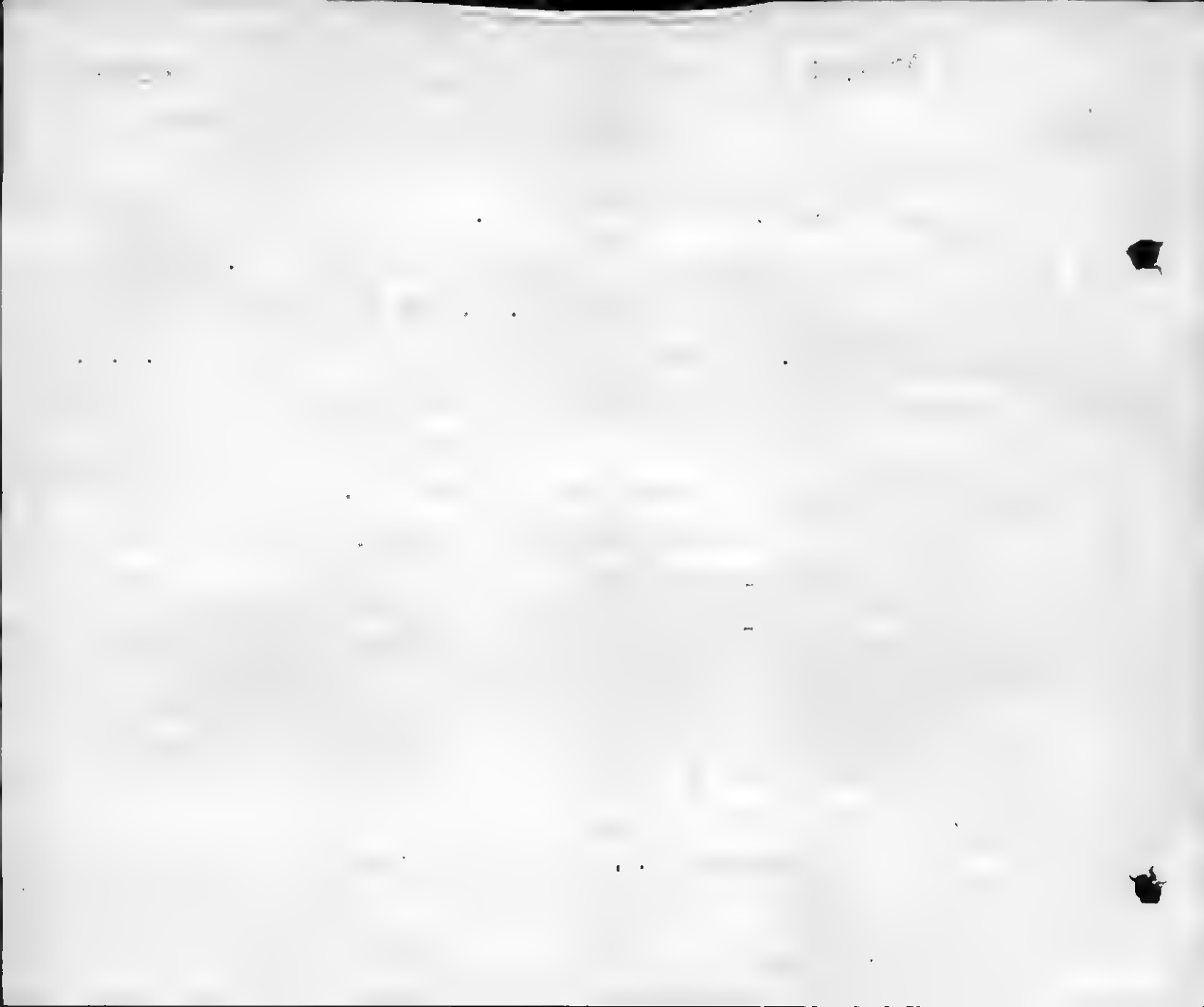
Ernest C. Gaither, Gaithersburg, Md.

25a. REC'D BY REGISTRAR  
DATE DEC 5 '61

25b. REGISTRAR'S SIGNATURE  
Arthur A. Pinner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/60

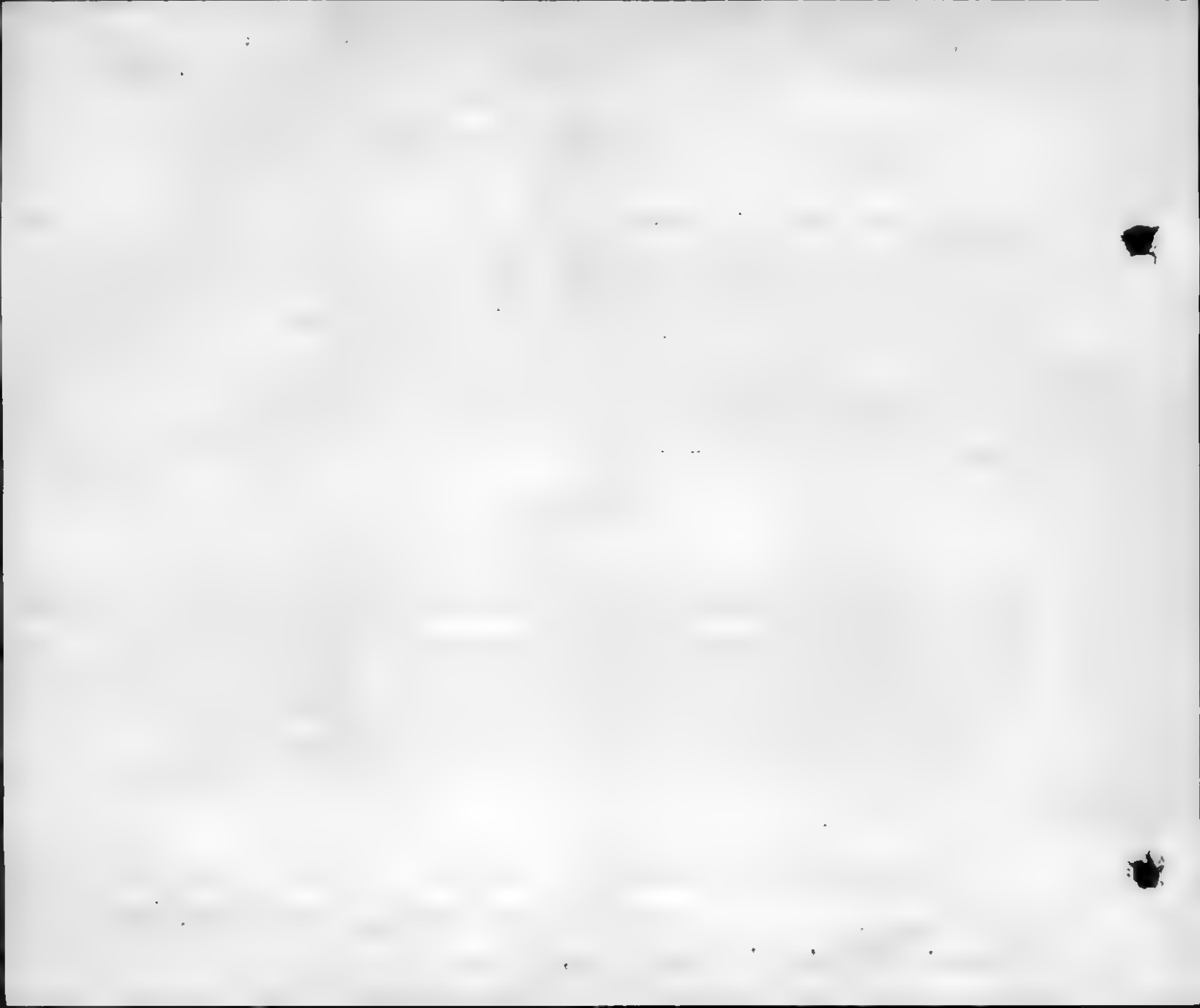


FOR STATE  
HEALTH DEPT.

TO LOCAL CITY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

<div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>12821</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> </div> <div> <div>12807</div> </div> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> c. LENGTH OF STAY IN TB <u>1 hr.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>111 Washington Grove Rd</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution. Residence before admission) a. STATE <u>md</u> b. COUNTY <u>monty</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>12324 Judson Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <u>John Franklin Hastings</u> 5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>7-16-1921</u> 9. AGE (in years last birthday) <u>40</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS.: Hours <u>0</u> Min. <u>0</u>						<b>4. DATE OF DEATH</b> <u>Nov 14 1961</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales manager</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Builders</u> 11. BIRTHPLACE (State or foreign country) <u>Ohio</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>					
<b>13. FATHER'S NAME</b> <u>Grove Hastings</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Jean Johnston</u> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u> <b>16. SOCIAL SECURITY NO.</b> <u>219-05-4828</u> <b>17. INFORMANT</b> <u>Grove Hastings (wife)</u> Address <u>Item 2</u>						<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>420.1</u> (c) <u>420.1</u> DUE TO (e), stating the underlying cause last.					
<b>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).</b> <u>History of previous coronary disease</u>											
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II or item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <u>11 19 61</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> <b>(County)</b> <b>(State)</b>											
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> <b>CHIEF MEDICAL EXAMINER</b> <b>DATE SIGNED</b> <b>ACTUAL SIGNATURE</b> <u>Frank J. Brosch</u> <b>ASSISTANT MEDICAL EXAMINER</b> <b>DEPUTY MEDICAL EXAMINER</b> <u>11-14-61</u> <b>EXAMINER'S NAME (Type)</b> <u>FRANK J. BROSCHE</u> <b>Address (Street, city, town, or county)</b> <b>(State)</b>											
<b>22a. BURIAL, CREMATION REMOVAL (Specify)</b> <u>Burial</u> <b>22b. DATE THEREOF</b> <u>11/17/61</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington National Cemetery Arlington County, Virginia</u> <b>22d. LOCATION (City, town, or country)</b> <b>(State)</b>											
<b>23. FUNERAL DIRECTOR</b> <u>WARNER E. PUMPHREY, INC.</u> <b>ADDRESS</b> <u>8434 GEORGIA AVENUE SILVER SPRING, MARYLAND</u> <b>24a. REC'D BY REGISTRAR</b> <u>Nov 16 '61</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>William S. Kraw</u>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY				b. COUNTY			
Montgomery				Virginia			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
Bel Pre Nursing Home				South Arlington			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
1607 Bel Blvd.				1607 26th Street			
3. NAME OF DECEASED (Type or print)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
Irene Rebecca HAZARD				11-28 1961			
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
F		W		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		10/3/87	
9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
74 yrs.		Months Days		Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (County & State, or foreign country)			
None				Derby, Conn.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
JOHN T. MC CARTHY				MARY G. LEONARD			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.			
NO				MRS FRANCES A. BRADLEY			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
PART I. DEATH WAS CAUSED BY:				INTERVAL BETWEEN ONSET AND DEATH			
4211 DUE TO				3 Mo.			
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.				10 years			
DUE TO				3 years			
Myocardial infarction							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e).							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED			
Hour a.m. p.m. 19				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
1961				Washington, D.C.			
21. I certify that (I) (this hospital) attended the deceased from NOV 4, 1961, to NOV 28, 1961, that (I) (we) last saw the deceased alive on NOV 26, 1961, and that death occurred at 1:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE				22b. DATE SIGNED			
Max G. Sherer MD				11/28/61			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
MAX G. SHERER MD				2025 EAST West H'way S.W. Sp. Md			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
BURIAL		11/30/61		Mount Olivet Cem.		Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE				25a. REC'D BY REGISTRAR			
Arlington Funeral Home				25b. REGISTRAR'S SIGNATURE			
3901 No. Fairfax Dr.				DATE NOV 30 '61			
Arlington 3, Va.							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12823						12809					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY <b>Montgomery</b>						a. STATE <b>California</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>						b. COUNTY <b>San Gabriel</b>					
c. LENGTH OF STAY IN TB <b>18 days</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>410 East Sunset Avenue</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>						d. STREET ADDRESS <b>410 East Sunset Avenue</b>					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First Middle Last <b>Arthur (None) Hernandez</b>						Month Day Year <b>November 2 19 61</b>					
5. SEX <b>Male</b>						6. COLOR OR RACE <b>Spanish</b>					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>						8. DATE OF BIRTH <b>December 4, 1934</b>					
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. <b>26 yrs.</b> Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>						10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>					
11. BIRTHPLACE (County & State, or foreign country) <b>California</b>						12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Ralph Hernandez</b>						14. MOTHER'S MAIDEN NAME <b>Louise Vasquez</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>						16. SOCIAL SECURITY NO <b>Unascertainable</b>					
17. INFORMANT <b>The Medical Record</b>						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>754.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)						Congenital Heart Disease - Tricuspid atresia					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Post-operative hemorrhage following superior vena cava to right pulmonary artery anastomosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>26 years</b>					
25a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>						25b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)					
21. I certify that (this hospital) attended the deceased from <b>October 15, 1961</b> that (we) last saw the deceased alive on <b>November 2, 1961</b> and that death occurred at <b>4:50 PM</b> from the causes and on the date stated above.						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
22a. SIGNATURE <b>Richard P. Anderson</b>						22b. DATE SIGNED <b>11/4/61</b>					
22c. PHYSICIAN'S NAME (Type) <b>Richard P. Anderson, M.D.</b>						22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>						23b. DATE THEREOF <b>11/8/61</b>					
23c. NAME OF CEMETERY OR CREMATORY <b>Washington</b>						23d. LOCATION (City, town or county) (State) <b>Alhambra, Calif.</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co.</b>						25a. REC'D BY REGISTRAR <b>NOV 8 '61</b>					
ADDRESS <b>Washington</b>						25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>					



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12824

12810

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY, IN 1b <u>17 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont. Co.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> d. STREET ADDRESS <u>2806-Hardy Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Neal N. Herndon</u>				<b>4. DATE OF DEATH</b> <u>Nov. 12 1961</u>			
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>9/11/189</u>	
<b>9. AGE</b> (In years, last birthday) <u>72</u> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Alabama</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>	
<b>13. FATHER'S NAME</b> <u>George Herndon</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Addie Linton</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>				<b>16. SOCIAL SECURITY NO.</b> <u>no</u>			
<b>17. INFORMANT</b> <u>George L. Herndon</u>				<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> (b) <u>Circulatory failure</u> (c) <u>Lymphosarcoma</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				<b>20. INTERVAL BETWEEN ONSET AND DEATH</b> <u>2 days 6 Hrs</u>			
<b>MEDICAL CERTIFICATION</b> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>1946</u> to <u>11/12/61</u> , that (I) (we) last saw the deceased alive on <u>11/12/61</u> , and that death occurred at <u>4:50 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>John W. Latimer, Jr.</u> M.D.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>John W. Latimer, Jr.</u>				22d. ADDRESS <u>1728 Mass Ave N.W. Wash. D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>11/15/61</u>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>November 15, 1961</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. H. Nune Co.</u> ADDRESS <u>2801-N. H. W. Wash. D.C.</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 14 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>William E. Harris</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. See 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12825

## CERTIFICATE OF DEATH

12811

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>13 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>428 Pershing Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Rosa Frances Hettinger</u>		<b>4. DATE OF DEATH</b> <u>November 5 1961</u>	
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>3/15/89</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Treasury Dept.</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>U.S. Govt.</u>	<b>9. AGE</b> (In years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS: Hours <u>  </u> Min. <u>  </u>
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Virginia</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>United States</u>	
<b>13. FATHER'S NAME</b> <u>William Lowe</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Catherine Brown</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>	
<b>17. INFORMANT</b> <u>Hospital Record</u>		<b>Address</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive failure of heart</u> 420.1 DUE TO (b) <u>Myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Coronary artery thrombosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerotic cardiovascular disease</u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>24 hr</u>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Jan 5, 1959</u> to <u>Nov 5, 1961</u> , that (I) (we) last saw the deceased alive on <u>5 Nov. 1961</u> , and that death occurred at <u>11:30 AM</u> from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <u>Ernest E. Farmer</u> M.D.		<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>	
<b>22c. PHYSICIAN'S NAME</b> (Type)		<b>22d. ADDRESS</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>11/8/61</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Fort Lincoln</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Prince George's County, Maryland</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Warner E. Humphrey, Inc.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>NOV 7 '61</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Howard</u>		<b>25c. REGISTRAR'S SIGNATURE</b>	

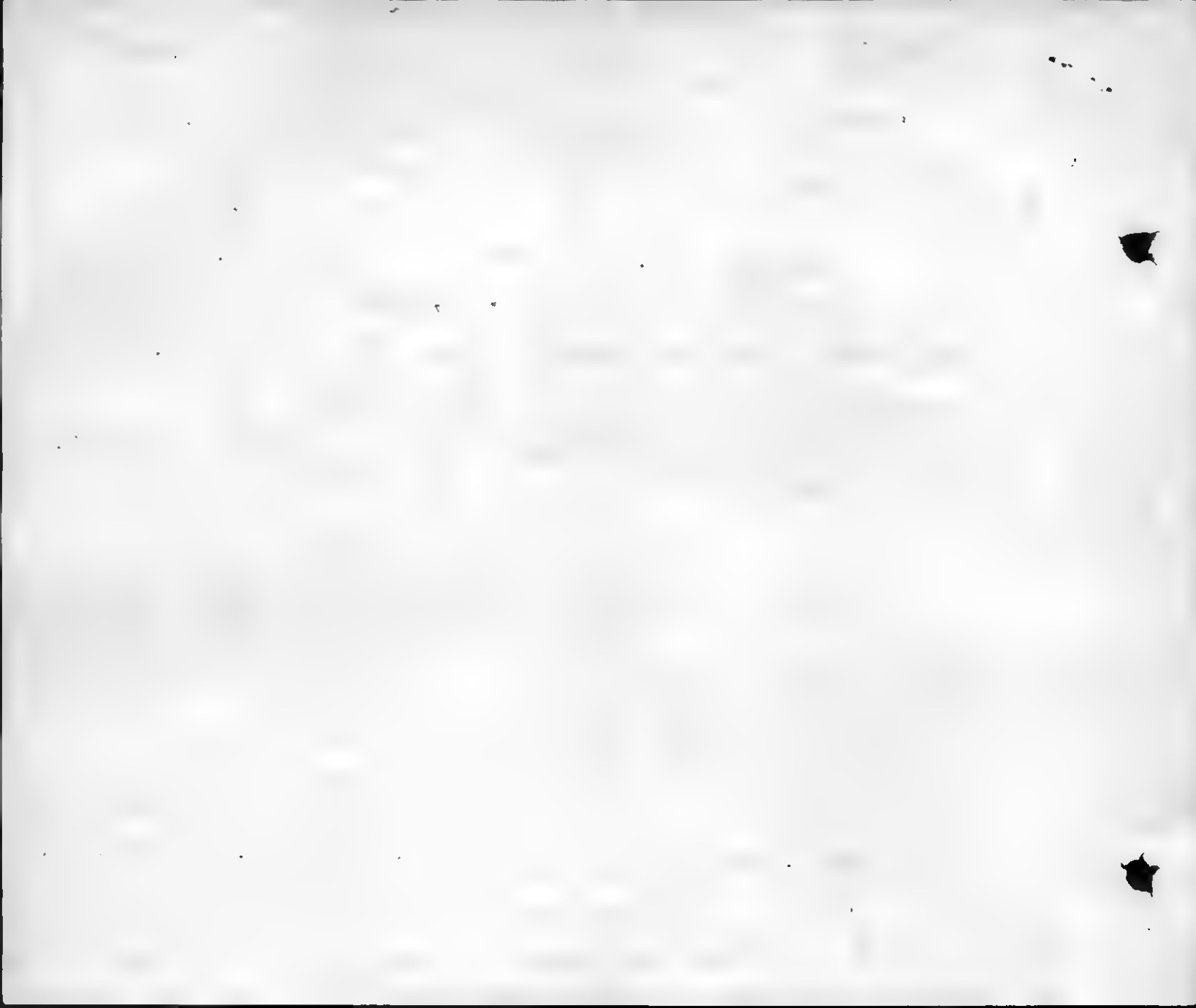


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 4, MARYLAND														
12826 CERTIFICATE OF DEATH 12812														
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. STREET ADDRESS <b>7009 Clarendon Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>NATHAN K. HILL</b>					4. DATE OF DEATH <b>Nov. 10, 1961</b>									
5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <b>Oct. 20, 1888</b> 9. AGE (in years last birthday) <b>73</b> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours M. n.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Greens Cutter-Country Club-Retired</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>					11. BIRTHPLACE (County & State, or foreign country) <b>U. S.</b>				
13. FATHER'S NAME <b>Levi Hill</b>					14. MOTHER'S MAIDEN NAME <b>Julia Marsden</b>					15. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>No</b> (Yes, no or unknown) (If yes give war or dates of service)				
16. SOCIAL SECURITY NO. <b>219-01-3890</b>					17. INFORMANT <b>Freida Hill</b>					Address <b>Same as Item #2.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro Vascular Accidents</b> <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Heart Disease</b> (c) <b>DIABETES Mellitus</b>										INTERVAL BETWEEN ONSET AND DEATH <b>10 DAYS</b> <b>10 YRS</b> <b>10 YRS</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
20f. (City or town) (County) (State)														
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1937</b> to <b>Nov 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov 10 1961</b> , and that death occurred at <b>12:30 P.M.</b> from the causes and on the date stated above.														
22a. SIGNATURE <b>Leo I. Donovan</b>					22b. DATE SIGNED <b>11-10-61</b>									
22c. PHYSICIAN'S NAME (Type) <b>LEO I. DONOVAN</b>					22d. ADDRESS <b>8218 Wisconsin Ave., Bethesda, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					23b. DATE THEREOF <b>11-13-61</b>					23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>				
23d. LOCATION (City, town or county) <b>Rockville, Maryland</b>														
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>					ADDRESS <b>Bethesda, Md.</b>					25a. REC'D BY REGISTRAR <b>DATE NOV 14 '61</b>				
										25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>				



1. **FOR STATE HEALTH DEPT.** **X**  
**M**  
**I**  
**2**  
**15**  
**2**

TO DIRECTOR, MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div> <div> <div>1</div> <div>2</div> <div>3</div> </div> <div> <div>4</div> <div>5</div> <div>6</div> </div> <div> <div>7</div> <div>8</div> <div>9</div> </div> </div> <div> <div>10</div> <div>11</div> <div>12</div> </div> <div> <div>13</div> <div>14</div> <div>15</div> </div> <div> <div>16</div> <div>17</div> <div>18</div> </div> <div> <div>19</div> <div>20</div> <div>21</div> </div> <div> <div>22</div> <div>23</div> <div>24</div> </div>												<div> <div> <div>1</div> <div>2</div> <div>3</div> </div> <div> <div>4</div> <div>5</div> <div>6</div> </div> <div> <div>7</div> <div>8</div> <div>9</div> </div> </div> <div> <div>10</div> <div>11</div> <div>12</div> </div> <div> <div>13</div> <div>14</div> <div>15</div> </div> <div> <div>16</div> <div>17</div> <div>18</div> </div> <div> <div>19</div> <div>20</div> <div>21</div> </div> <div> <div>22</div> <div>23</div> <div>24</div> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY IN <u>MD</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Md R-107</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Dickerson (rural)</u> d. STREET ADDRESS <u>1 RFD # 2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
<b>3. NAME OF DECEASED</b> (Type or print) <u>George Kenneth Hood</u> First Middle Last						<b>4. DATE OF DEATH</b> <u>Nov 26 1961</u> Month Day Year																	
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>col</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>11-19-08</u>		<b>9. AGE</b> (In years last birthday) <u>53</u> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.													
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>labour</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>MD.</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>MD.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>													
<b>13. FATHER'S NAME</b> <u>George C. Hood</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Florence Johnson</u>																	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>						<b>16. SOCIAL SECURITY NO.</b> <u>none</u>		<b>17. INFORMANT</b> <u>Mrs Evelyn Herbert Stem # 2</u>															
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exsanguination</u> DUE TO (b) <u>Transsection of Aorta</u> (c) <u>Crushed Chest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>Sudden</u> <u>Sudden</u> <u>Sudden</u>											
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)</b>																							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Driver of car involved in accident</u>																			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>3:45</u> P.M. <u>11-26 1961</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Md R-107</u>		<b>20f. (City or town)</b> <u>Rockville</u>		<b>(County)</b> <u>Montgomery</u>		<b>(State)</b> <u>MD</u>											
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschart</u>						<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DATE SIGNED</b>													
<b>EXAMINER'S NAME (Type)</b> <u>FRANK J. BROSCHEIT</u>						<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>11-27-61</u>													
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>						<b>22b. DATE THEREOF</b> <u>11/30/61</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington Cemetery.,</u>				<b>22d. LOCATION (City, town, or country)</b> <u>Arlington, Va.</u>											
<b>23. FUNERAL DIRECTOR</b> <u>Robert L. Snowden</u>						<b>ADDRESS</b> <u>Rockville, Md.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>NOV 30 '61</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Robert L. Snowden</u>													

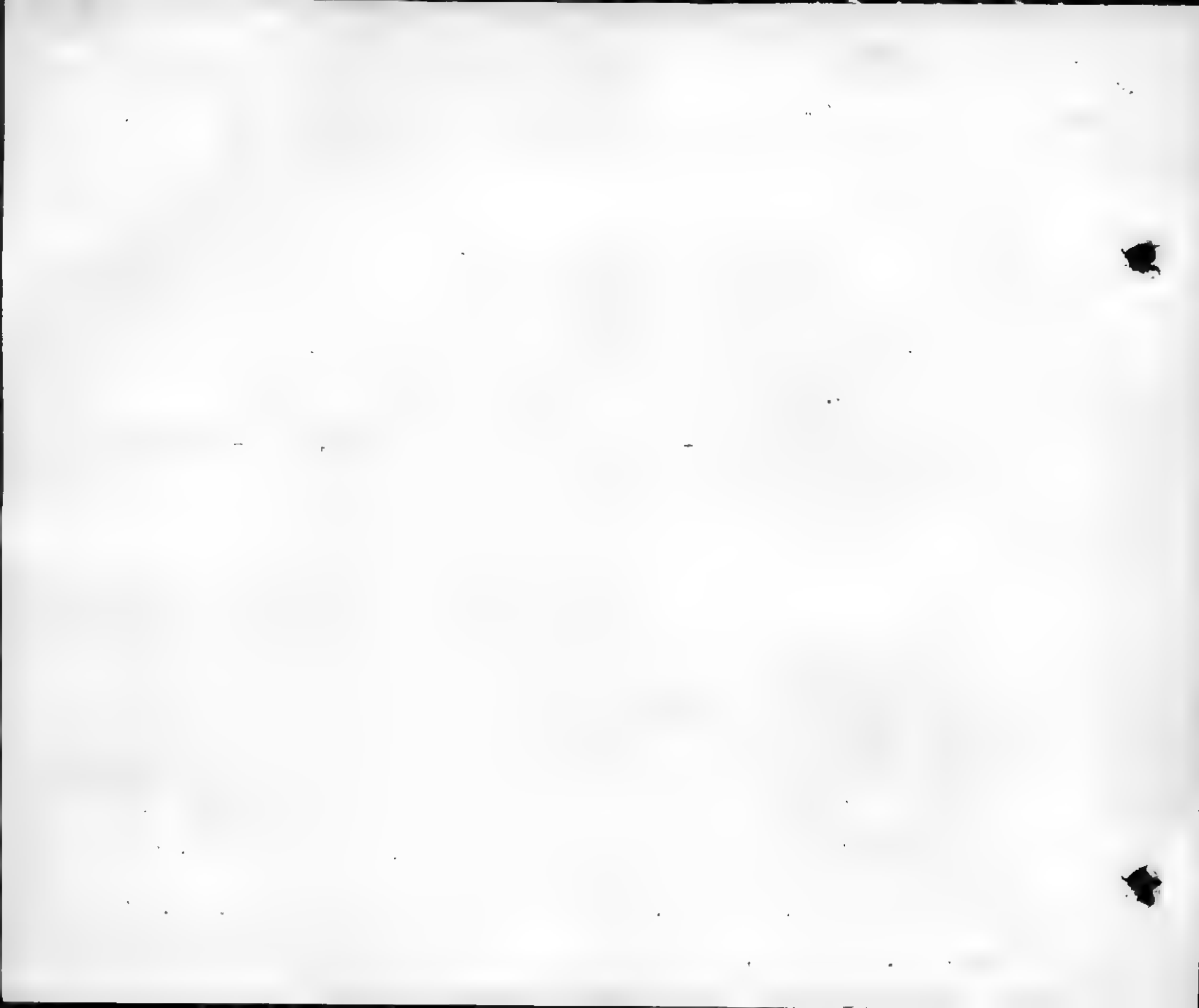


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)  
 15M 9/59

1  
 12828  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH  
 12814

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4601 Cooper Lane</b>				d. STREET ADDRESS <b>4601 Cooper Lane</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>F</b> Last <b>Horne</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>17</b> Year <b>1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/22/1879</b>		9. AGE (in years last birthday) <b>82</b> yrs	IF UNDER 1 YEAR Months <b>5</b> Days <b>25</b>	IF UNDER 24 HRS Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Robert L. Horne</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth McFadden</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>Spanish American</b>				16. SOCIAL SECURITY NO. <b>577-03-1346</b>		17. INFORMANT <b>Josephine M Horne, Wife-same above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute heart failure</b> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
					20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 21, 1961</b> to <b>Nov. 14, 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov 14, 1961</b> , and that death occurred <b>2:55 PM</b> from the causes and on the date stated above							
22a. SIGNATURE <b>C. P. Ryland</b>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>11-17-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>C. P. RYLAND</b>				22d. ADDRESS <b>4400 - 49 ST NW Washington DC</b>			
23a. BURIAL, CREMATION, REMOVAL (specify) <b>Burial</b>		23b. DATE THEREOF <b>11/20/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Prince Geo. Co., Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>				25a. REC'D BY REGISTRAR <b>Nov 22 '61</b>		25b. REGISTRAR'S SIGNATURE <b>C. S. K...</b>	

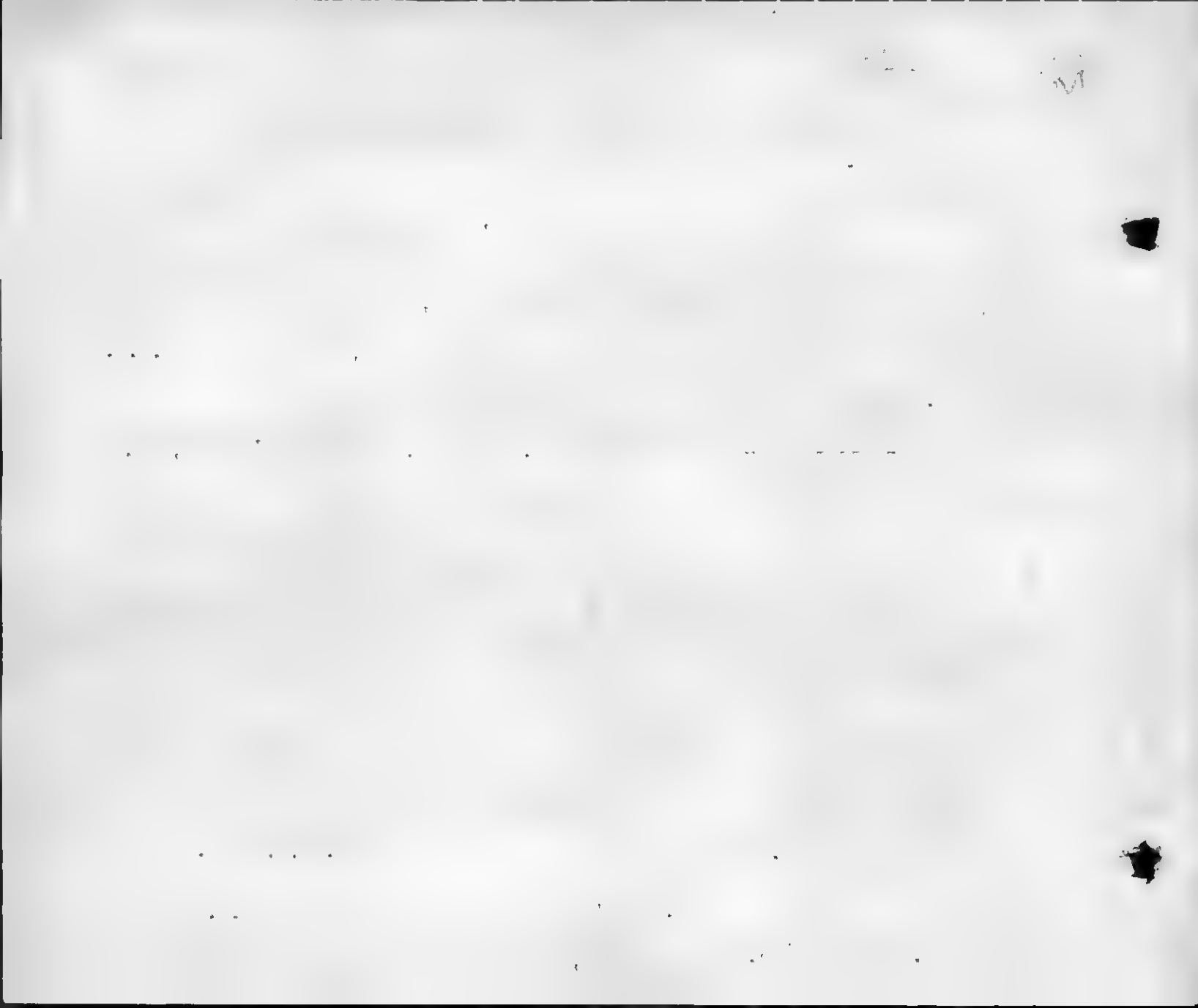


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
12829  
12815  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colesville Md.		c. LENGTH OF STAY IN IN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Marilea Nursing Home		d. STREET ADDRESS 11,605 Gail Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CARRIE GERTRUDE HURLEY		4. DATE OF DEATH November 5 1961		5. SEX Female	
6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH February 1, 1892	
9. AGE (In years last birthday) 69 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) Calvert County, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Emory E. Berry		14. MOTHER'S MAIDEN NAME Eliza Johnson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO None		17. INFORMANT Mrs. Harvey L. Glasscock	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO (b) Cardio-vascular arterio-sclerosis DUE TO (c) Generalized arterio-sclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 12 weeks 4 yrs 4 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Amputation of the left leg just above the knee.		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Washington D.C.		20g. (County) Washington D.C.		20h. (State) Washington D.C.	
21. I certify that (I) (this hospital) attended the deceased from 11/1/61 to 11/5/61, 1961, that (I) (we) last saw the deceased alive on 11/4/61, 1961, and that death occurred at 7 A.M. from the causes and on the date stated above.					
22a. SIGNATURE Walter K. Angevine					
22b. PHYSICIAN'S NAME (Type) Walter K. Angevine					
22c. ADDRESS 6300 13th St. N.W. Wash. DC					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					
23b. DATE THEREOF 11/8/61					
23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery					
23d. LOCATION (City, town or county) Washington D.C.					
24. FUNERAL DIRECTOR'S SIGNATURE Raymond H. Zisk					
24a. ADDRESS 434 Georgia Avenue Silver Spring, Maryland					
25a. REC'D BY REGISTRAR Nov 7 '61					
25b. REGISTRAR'S SIGNATURE Arthur S. Huns					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

12830

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MD

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M

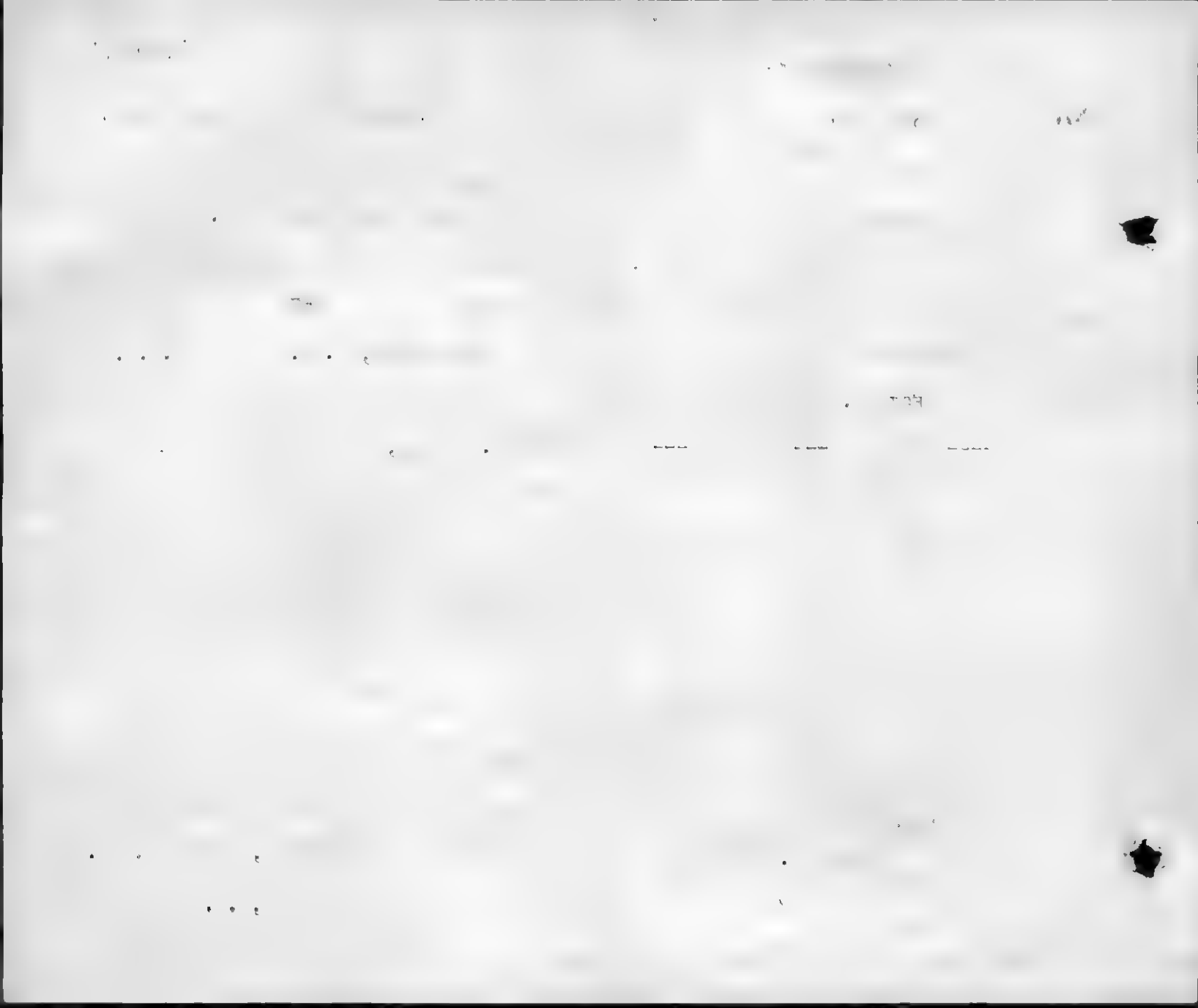
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY in 1b <u>2 1/2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>8616 Beach Tree Road.</u>	
3. NAME OF DECEASED (Type or print) <u>Clara G. Hurley</u>		4. DATE OF DEATH Month <u>November</u> Day <u>21</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/7/06</u>
9. AGE (In years last birthday) <u>55</u> s		10. IF UNDER 1 YEAR, IF UNDER 24 HRS., Months <u>5</u> Days <u>5</u> Hours <u>5</u> Min. <u>5</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. PLACE (County & State, or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alfred B. Gawler</u>		14. MOTHER'S MAIDEN NAME <u>Sally Hager</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>---</u>		16. SOCIAL SECURITY NO. <u>---</u> 17. INFORMANT <u>Glenn S. Hurley, husband</u> Address <u>same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Thrombosis</u> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> a.m. <u>---</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JAN. 25, 1959</u> to <u>NOV. 21, 1961</u> , that (I) (we) last saw the deceased alive on <u>Nov. 21, 1961</u> , and that death occurred at <u>11:10 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert G. Angle</u>		22b. DATE SIGNED <u>Nov. 21, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT G. ANGLE</u>		22d. ADDRESS <u>5009 DEL RAY AVENUE, BETHESDA, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11/24/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>OAK HILL CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>WASHINGTON, D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Gauders Sons Inc.</u>		25a. REC'D BY REGISTRAR <u>NOV 24 '61</u> DATE	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

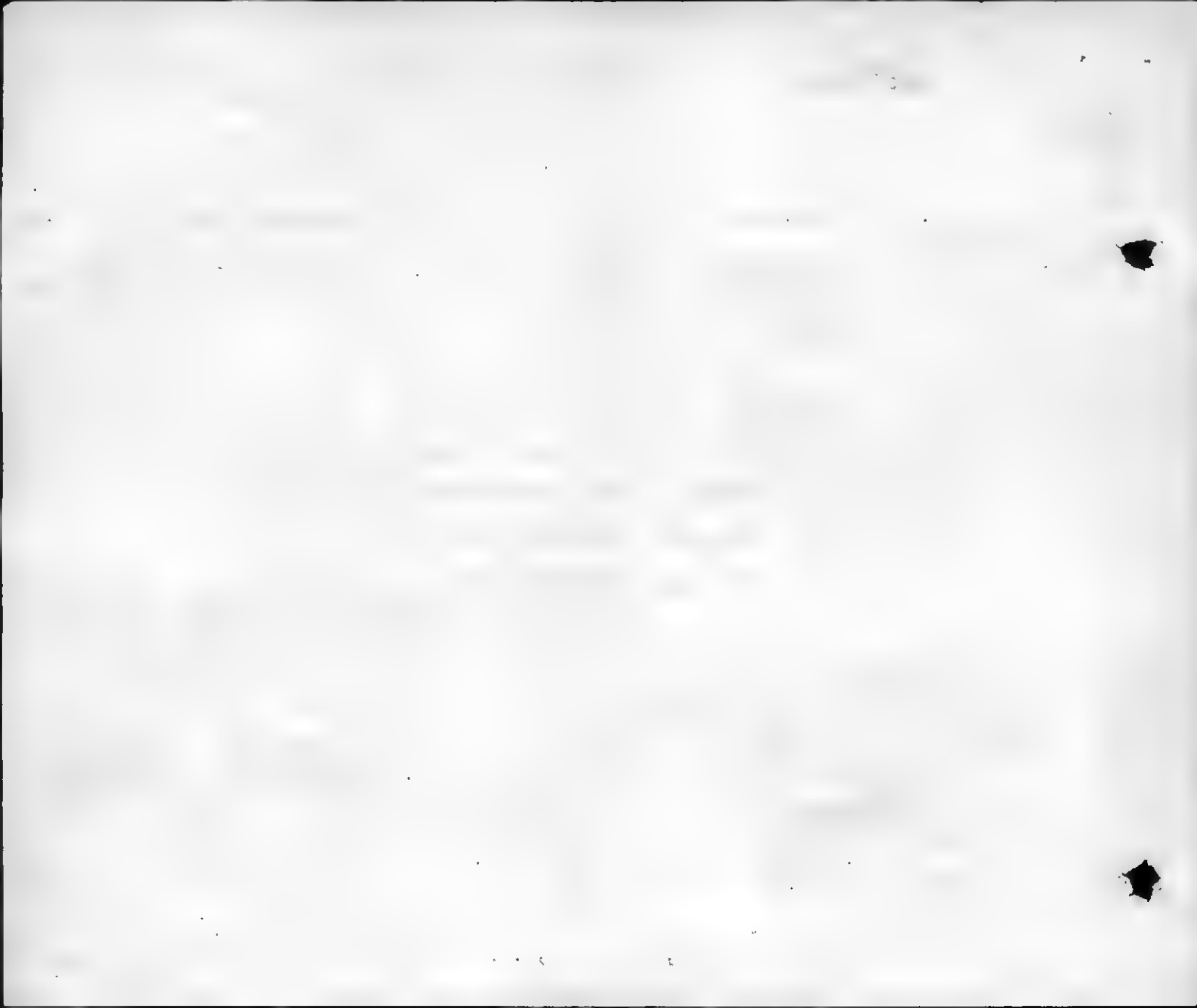


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO VITAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7 61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN 1b <u>5 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>James</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MC3 Quantico</u> d. STREET ADDRESS <u>Strs. 2304B Chamberlain Village</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>Lloyd</u> Last <u>Jackson</u>		4. DATE OF DEATH Month <u>November</u> Day <u>22</u> Year <u>19 61</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negroid</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 22, 1935</u> 26 yrs.	
9. AGE (In years last birthday) Months Days Hours Min		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Serviceman</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Brandon Jackson</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>161-26 4789</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (b) <u>Brain Stem Hemorrhage</u> (c) <u>basilar skull fracture</u> <u>automobile accident</u> DUE TO <u>8-25X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 <u>Nov. 18, 1961</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (this hospital) attended the deceased from <u>Nov. 18, 1961</u> to <u>Nov. 22, 1961</u> that (we) last saw the deceased alive on <u>Nov. 22, 1961</u> , and that death occurred at <u>8:17 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>G. A. Macoid</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED <u>November 22, 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>G. A. MACOID LT MC USNR</u>			
22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
23b. DATE THEREOF <u>11-27 61</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>			
23d. LOCATION (City, town or county) (State) <u>Arlington, Va.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>B.T. Taylor Inc.</u> ADDRESS <u>909 6th St NW, Washington, D.C.</u>			
25a. REC'D BY REGISTRAR <u>NOV 27 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7 61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12832

Item 2, b, File 6300 11/13/61 iwc

12818

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before edm ss on) a. STATE <u>Texas</u> b. COUNTY _____	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Dallas</u>	
c. LENGTH OF STAY IN 1b <u>152 days</u>		d. STREET ADDRESS <u>4211 Munger Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Opal</u> Middle <u>Vera</u> Last <u>Jackson</u>		4. DATE OF DEATH Month <u>November</u> Day <u>5</u> Year <u>19 61</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Caucasian</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 4, 1916</u>	
9. AGE (In years last birthday) <u>45</u> yrs.		10. IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (County & State, or foreign country) <u>Mississippi</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jake Goodnight</u>		14. MOTHER'S MAIDEN NAME <u>Dora Rayborn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>HUS: Deloyd Jackson, Same as #2</u>	
17. INFORMANT <u>HUS: Deloyd Jackson, Same as #2</u>		Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>450</u> DUE TO <u>GANGRENE OF LOWER EXTREMITIES</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PROGRESSIVE ARTERIAL OCCLUSION</u> (c) <u>ARTERIOSCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>June 20, 19 61</u> to <u>November 5, 1961</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>November 5, 19 61</u> , and that death occurred <u>5:40 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Benjamin J. Gilson</u>		22b. DATE SIGNED <u>6 November 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>BENJAMIN J. GILSON LT MC USN</u>		22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/9/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ben Wheeler</u>		25a. REC'D BY REGISTRAR <u>NOV 8 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>		25c. ADDRESS <u>1331 Rockville, Md.</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director. After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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APR 15 1961

MEDICAL CERTIFICATION

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**CERTIFICATE OF DEATH**

12833 Item 9 Film G302 12/13/61 iwk 12819

1. PLACE OF DEATH  
a. COUNTY MONTGOMERY MARYLAND  
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) BETHESDA  
c. LENGTH OF STAY IN IL 24 days  
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUBURBAN Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)  
a. STATE MARYLAND MONTGOMERY  
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) CHEVY CHASE  
c. STREET ADDRESS Raymond St. 3704  
d. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) RAY FISHER JACKSON  
4. DATE OF DEATH Nov. 30 1961  
5. SEX Female 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH 4/18/87  
9. AGE (In years, last birthday) 74 Yrs. 10. UNDER 1 YEAR ☐ 11. UNDER 24 HRS. ☐ 12. CITIZEN OF WHAT COUNTRY? U.S.A

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY EASH. D.C. 11. BIRTHPLACE (Country, & State, or foreign country) U.S.A  
13. FATHER'S NAME CHARLES FISHER 14. MOTHER'S MAIDEN NAME ELLA DORAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? NO 16. SOCIAL SECURITY NO. 579-46-6407B 17. INFORMANT HUSBAND FRANK JACKSON (SAME AS ABOVE) Address \_\_\_\_\_

18. CAUSE OF DEATH (Enter only one cause pertinent for (a), (b), and (c))  
PART I. DEATH WAS CAUSED BY:  
3-4X IMMEDIATE CAUSE (a) Left hemiplegia, severe  
Right hemiplegia, severe, with aphasia  
Cerebral arteriosclerosis, severe  
DUE TO (b) 5 yrs  
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. Essential Hypertension  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) \_\_\_\_\_

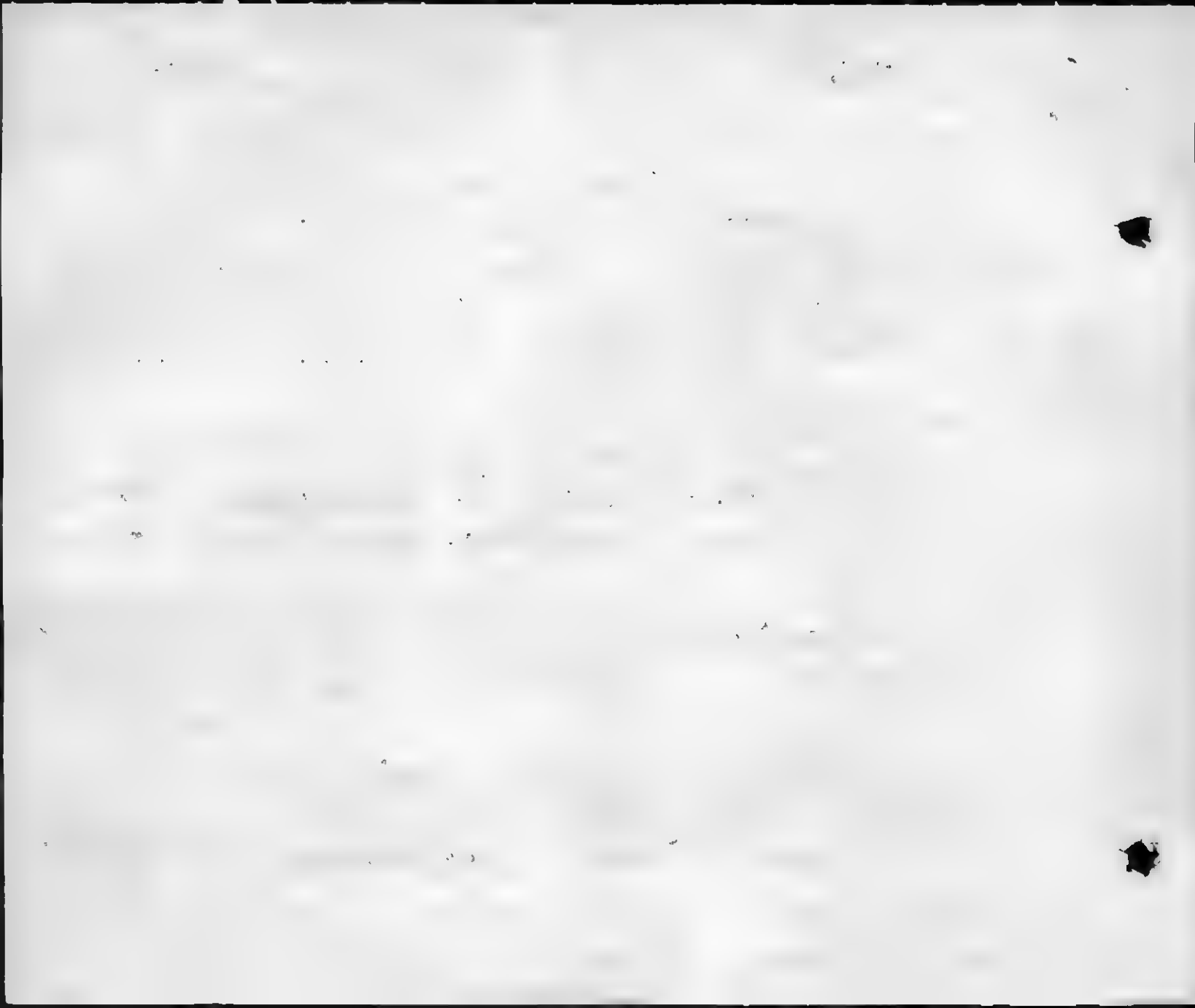
20c. TIME OF INJURY Month, Day, Year Hour a.m. \_\_\_\_\_ p.m. \_\_\_\_\_ 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) \_\_\_\_\_ 20f. (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State) \_\_\_\_\_

21. I certify that (I) (this hospital) attended the deceased from APR 1947 to Nov 30, 1961, that (I) (u) last saw the deceased alive on Nov 30, 1961, and that death occurred at 11:40 PM, from the causes and on the date stated above

22a. SIGNATURE Stewart Clapp M.D. M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22b. DATE SIGNED 12.1.61  
22c. PHYSICIAN'S NAME (Type) Stewart Clapp 22d. ADDRESS 4740 Chevy Chase Dr Chevy Chase Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 23b. DATE THEREOF 12/4/61 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory 23d. LOCATION (City, town or county) Suitland, Maryland (State) \_\_\_\_\_

24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland 25a. REC'D BY REGISTRAR DEC 6 '61 25b. REGISTRAR'S SIGNATURE Arthur L. Hanna



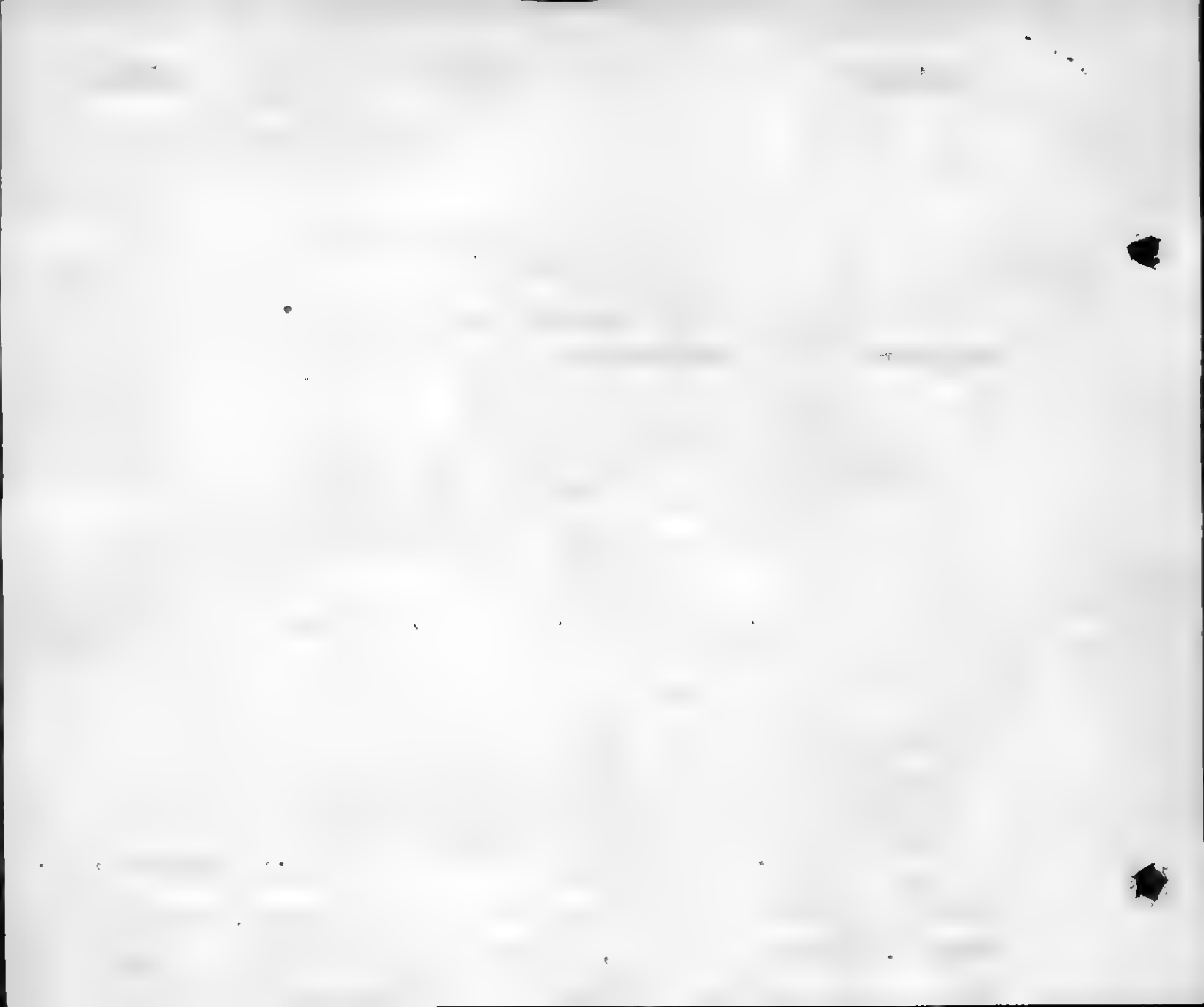
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Item 6 <u>611R G301</u> <u>11/29/61</u> <u>1wk</u> <u>128320</u>											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY in 1b <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>8001 Newdale Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Richard W. Johnston</u>				4. DATE OF DEATH Month <u>November</u> Day <u>17</u> Year <u>1961</u>							
5. SEX <u>M</u>				6. COLOR OR RACE <u>W.</u>				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>May 29, 1917</u> yrs. <u>44</u>			
10a. USUAL OCCUPATION (Give usual work done during most of working life, even if retired) <u>Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Electronics</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Boston - Mass</u>			
13. <u>John C. Johnston</u>				14. MOTHER'S MAIDEN NAME <u>Ann F. Perkins</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>				17. INFORMANT <u>John C Johnston Jr</u> Address <u>4000 Mass Ave Wash DC</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>585X</u> DUE TO <u>Sepsicemia, type(?)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Gangrene, gall bladder</u> (c) <u>Cholecystectomy (11/15/1961)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cholecystectomy (11/15/1961)</u>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year <u>11-15-61</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>11-15-61</u> 20f. (City or town) <u>Bethesda</u> (County) <u>Montgomery</u> (State) <u>Md.</u>											
21. I certify that (I) (this hospital) attended the deceased from <u>11-15-61</u> , 19 <u>61</u> , to <u>11-17-61</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>11-17-61</u> , 19 <u>61</u> , and that death occurred at <u>11-17-61</u> , 19 <u>61</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>John O. Robben</u> M.D. 22b. DATE SIGNED <u>11-18-61</u>											
22c. PHYSICIAN'S NAME (Type) <u>John O. Robben</u> 22d. ADDRESS <u>10511 Summit Ave., Kensington, Md.</u>											
23a. BURIAL, CREMATION, 23b. DATE THEREOF <u>Burial</u> <u>11/22/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u> 23d. LOCATION (City, town or county) <u>Arlington, Virginia</u> (State) <u>VA</u>											
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u> 25a. REC'D BY REGISTRAR <u>11-22-61</u> 25b. REGISTRAR'S SIGNATURE <u>Robert A. Pumphrey</u>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

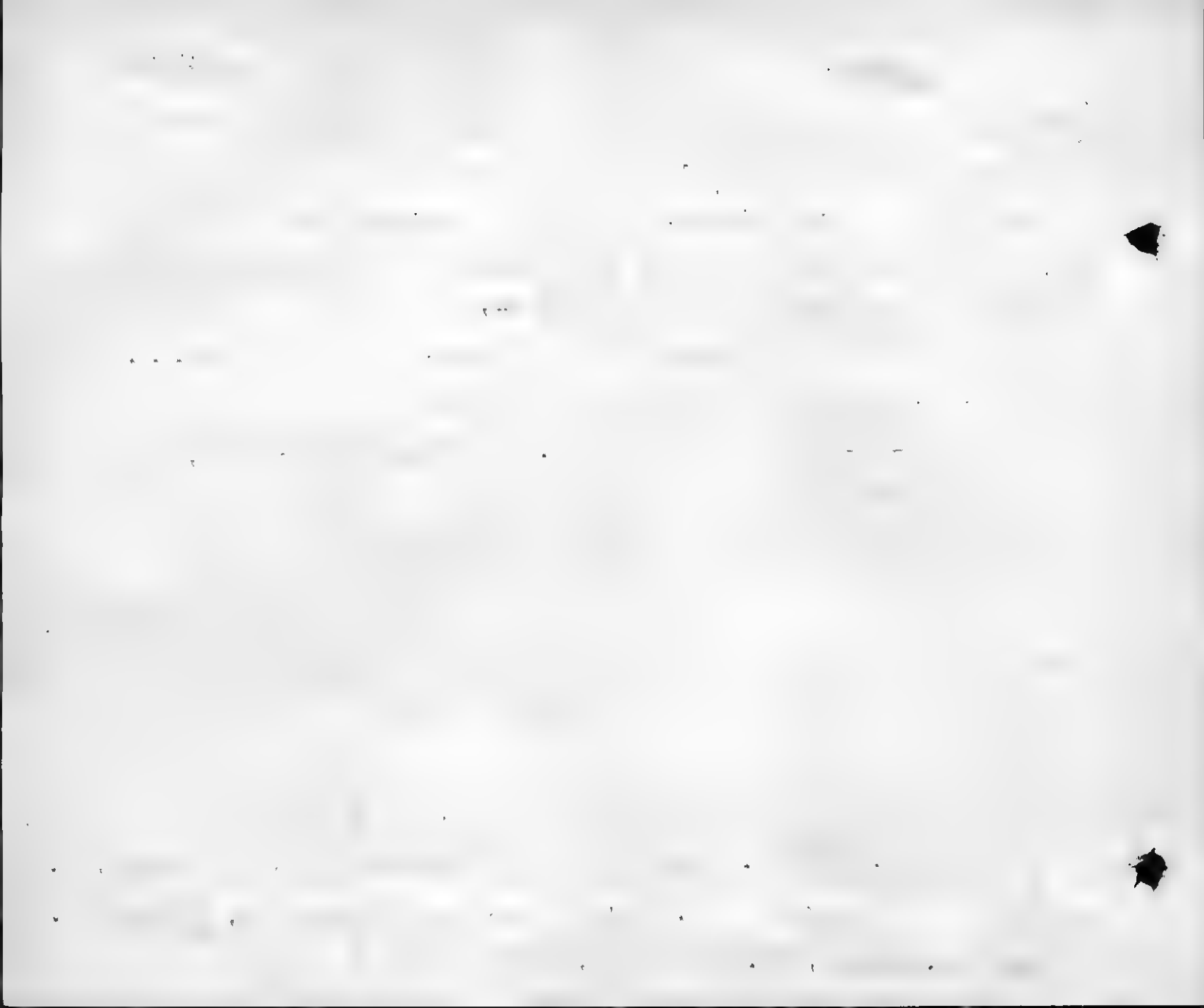
CERTIFICATE OF DEATH

12835

12821

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. LENGTH OF STAY IN lb <b>11 3/4 hours</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium &amp; Hospital</b>		d. STREET ADDRESS <b>302 Mansfield Road</b>	
3. NAME OF DECEASED (Type or print) <b>Nora Cecilia Kelley</b>		4. DATE OF DEATH <b>November 15, 1961</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOW <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 23, 1871</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13. FATHER'S NAME <b>Patrick Brodrick</b>		14. MOTHER'S MAIDEN NAME <b>Mary Lenard</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		17. INFORMANT <b>Mrs. Theresa McMahon</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Generalized Arteriosclerosis</b> 45710 DUE TO (b) <b>Terminal Bronchopneumonia and</b> DUE TO (c) <b>Congestive Failure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>20 yrs.</b> <b>4 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Silver Spring</b> (County) <b>Montgomery</b> (State) <b>Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>May 8, 1938</b> to <b>Jan 15, 1941</b> , that (I) (we) last saw the deceased alive on <b>11-15</b> , 19 <b>61</b> , and that death occurred at <b>5:45A</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Kenneth F. Laughlin</b>		22b. DATE SIGNED <b>11-15-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Kenneth F. Laughlin</b>		22d. ADDRESS <b>934 Ellsworth Drive, Silver Spring, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11/18/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. John's Catholic Cemetery Forest Glen, Montgomery Md.</b>		23d. LOCATION (City, town or county) <b>Silver Spring, Md.</b> (State) <b>Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond A. Ziska</b>		25a. REC'D BY REGISTRAR <b>NOV 17 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>William S. Frank</b>		25c. ADDRESS <b>8434 GEORGIA AVENUE</b>	
25d. CITY, STATE, ZIP <b>WARMER E. PUMPHREY, INC. SILVER SPRING, MARYLAND</b>		25e. ZIP <b>20910</b>	

VR A15 (4)  
15M 9/60



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

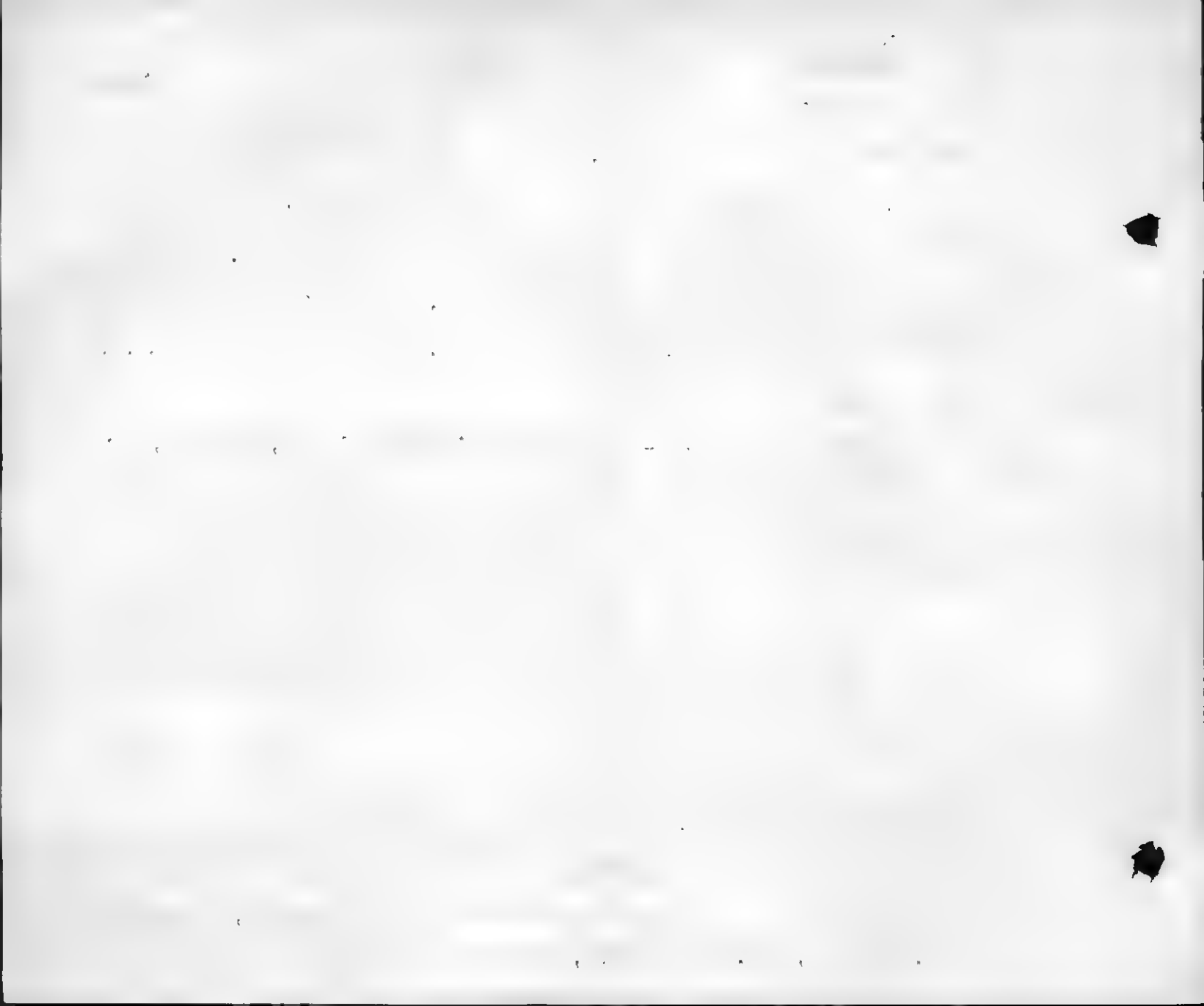
12836

## CERTIFICATE OF DEATH

12832

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>				2. USUAL RESIDENCE (Where deceased lived, if institution, list the name and address) e. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			
c. LENGTH OF STAY in 1b <b>1 1/2 hour</b>				d. STREET ADDRESS <b>5411 Lincoln Street</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Thomas Edward Kennedy</b>				4. DATE OF DEATH Month Day Year <b>Nov. 12 1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 20, 1899</b>	
9. AGE (In years last birthday) <b>62 yrs.</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>salesman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Hub Company</b>		11. BIRTHPLACE (Country & State, or foreign country) <b>New Hampshire</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Thomas Kennedy</b>			
14. MOTHER'S MAIDEN NAME <b>XX UNKNOWN</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes World War I</b>			
16. SOCIAL SECURITY NO <b>322-12-7078</b>				17. INFORMANT Address <b>Mrs. Sophia D. Kennedy, 5411 Lincoln Street, Bethesda, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiac Insufficiency</b> <b>Myocardial Infarction</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>None</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>1 hr.</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 1961</b> to <b>Nov. 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov. 12 1961</b> , and that death occurred at <b>8:58 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Ralph E. Patten</b>				22b. DATE SIGNED <b>Nov 14 1961</b>			
22c. PHYSICIAN'S NAME (Type) <b>RALPH E. PATTEN M.D.</b>				22d. ADDRESS <b>8644 Colverville Road Silver Spring, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/15/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery Arlington, Virginia</b>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Pumphrey, Inc.</b>				25a. REC'D BY REGISTRAR <b>NOV 14 '61</b>			
25b. REGISTRAR'S SIGNATURE <b>Charles L. Thomas</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director.



# MARYLAND STATE DEPARTMENT OF HEALTH

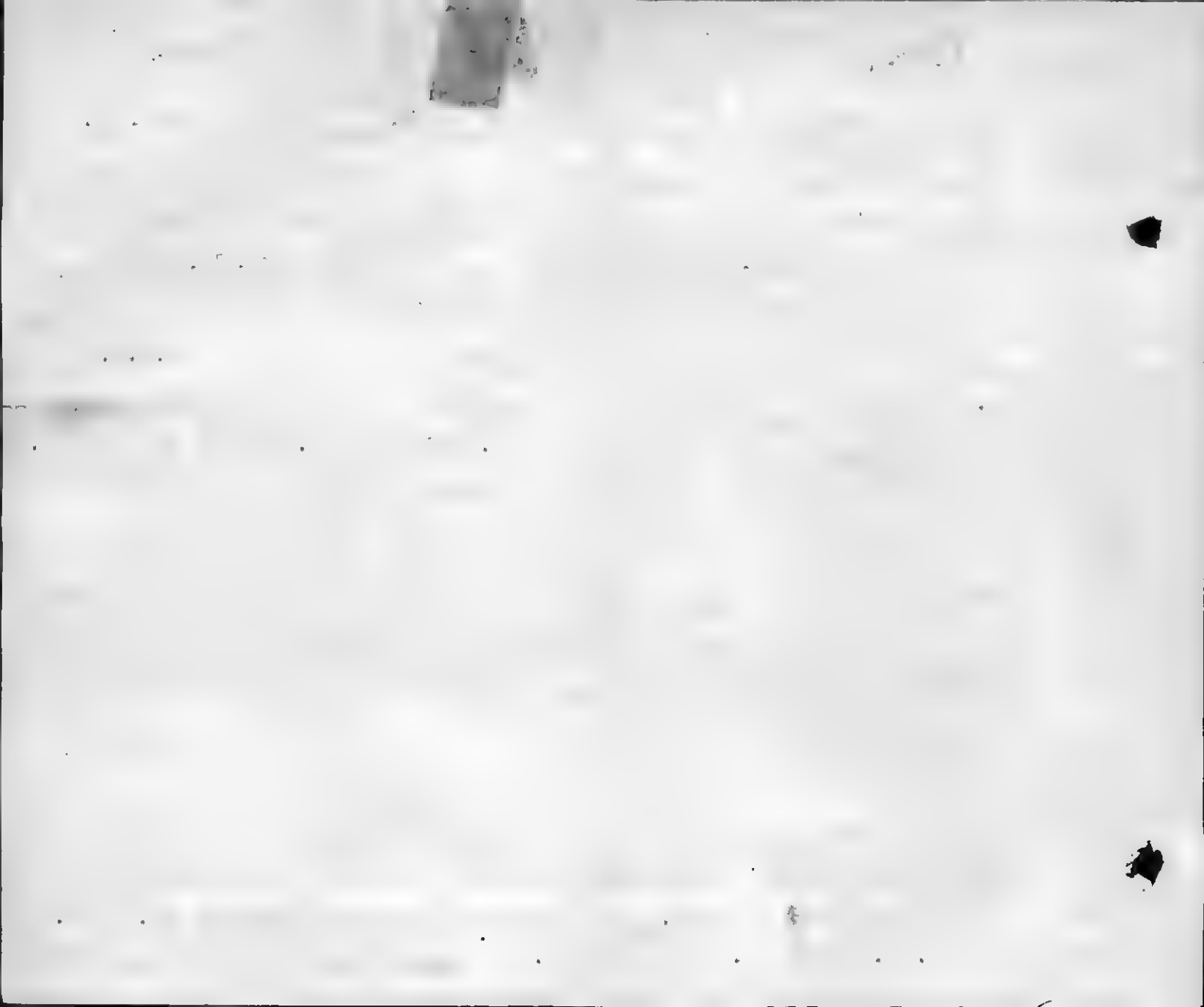
Division of STATISTICAL RESEARCH AND RECORDS, 130 PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

**1**  
**FOR STATE**  
**HEALTH DEPT.**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN <u>MARYLAND</u> <u>26 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington, D.C.</u> d. STREET ADDRESS <u>1424 Somerset Place N. Kensington Gardens Nursing Home</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Ina B. Kepner</u> First Middle Last		<b>4. DATE OF DEATH</b> <u>Nov. 12, 1961</u> Month Day Year	
<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>7/17/72</u> <b>9. AGE</b> (In years last birthday) <u>89</u> yrs.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Ohio</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>A. Peter</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Elizabeth Black</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> <b>16. SOCIAL SECURITY NO.</b> <u>none</u> <b>17. INFORMANT</b> <u>Mrs. Elizabeth C. George Silver Spg. Md.</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>332 X</u> <u>Cerebral infarction</u> <u>Arteriosclerosis</u> DUE TO (b) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of left femur</u> <u>5 weeks</u> <b>20a. EXTERNAL CAUSE OF DEATH</b> <u>20b. DESCRIBE HOW INJURY OCCURRED</u> (Enter nature of injury in Part I or Part II of item 18.) <u>Fell from chair in her room at nursing home - fracture of hip</u> <b>20c. TIME OF INJURY</b> Month, Day, Year <u>4:30 p.m. 10-16-1961</u> <b>20d. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Nursing home</u> <b>20e. (City or town)</b> <u>Kensington</u> <b>20f. (County)</b> <u>Mont.</u> <b>20g. (State)</b> <u>Md.</u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and in my opinion death resulted from</b> <u>Natural causes</u> <input checked="" type="checkbox"/> <b>Accident</b> <input type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined manner</b> <input type="checkbox"/>			
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschant</u> <b>EXAMINER'S NAME (Type)</b> <u>FRANK J. Broschant</u> <b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>cremation</u> <b>22b. DATE THEREOF</b> <u>11/15/61</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Ft. Lincoln Crematory Prince Georges Co. Md.</u> <b>22d. LOCATION (City, town, or country)</b> <u>Washington, D.C.</u> <b>22e. (State)</b> <u>Md.</u>			
<b>23. FUNERAL DIRECTOR</b> <u>The S. H. Hines Co. 2901 14th St. NW</u> <b>24a. REC'D BY REGISTRAR</b> <u>NOV 15 '61</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>Carlton S. Kinn</u>			

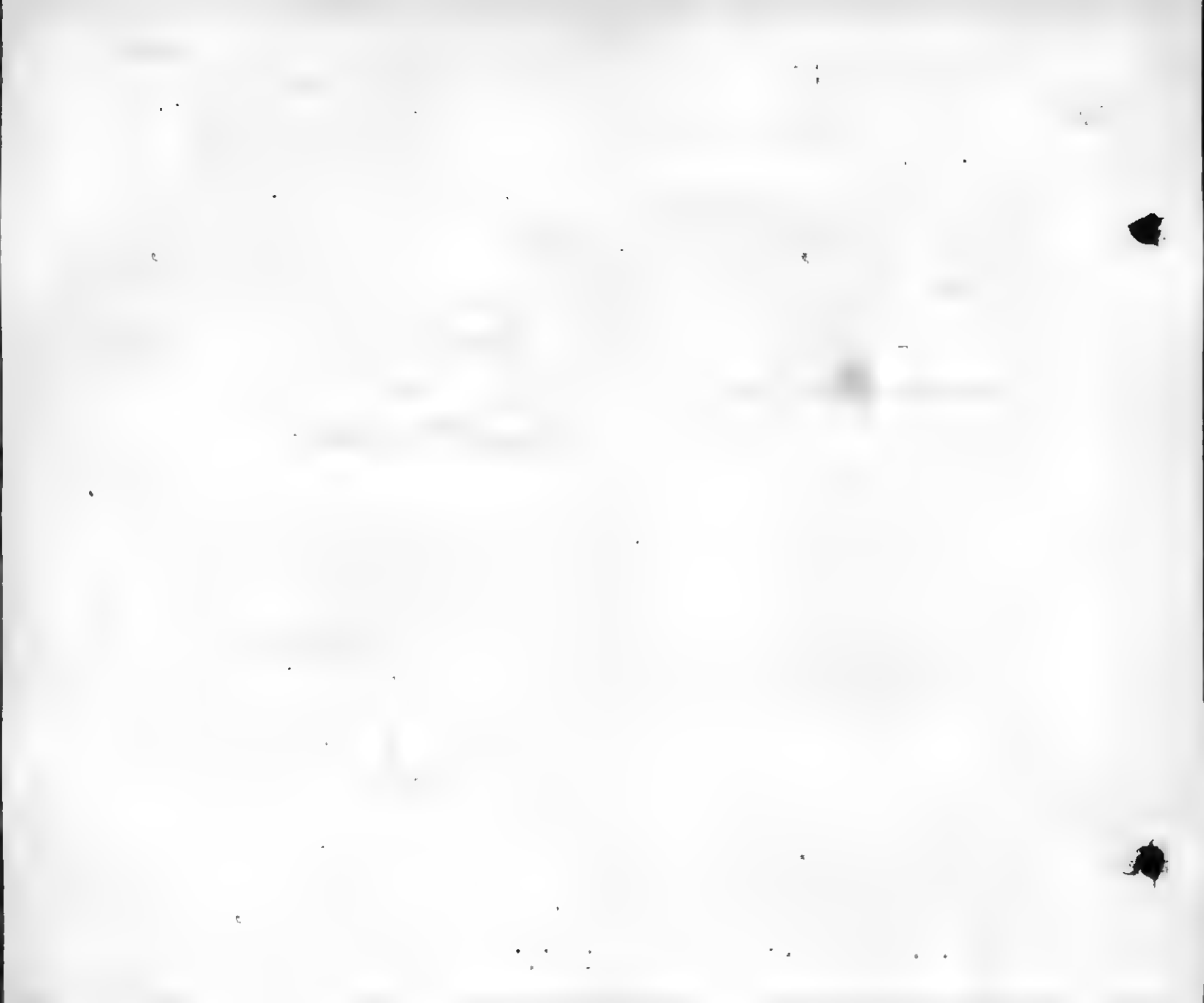
TO DEPARTMENT OF HEALTH: This certificate should be executed within 24 hours after death. If a delay is necessary, Page 1 should be executed by the medical director, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



12835

12824

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>1 mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> <u>1-1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>				d. STREET ADDRESS <u>9715-Culver St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Albert</u> First <u>Francis</u> Middle <u>Klatt</u> Last <u>Klatt, Albert Francis</u>				4. DATE OF DEATH Month <u>November</u> Day <u>1</u> Year <u>19 61</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>July 16, 1875-</u>		9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u>86</u> Days <u>86</u> Hours <u>86</u> Min. <u>86</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore-Md.</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Herman Klatt</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Hospital Records</u>				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>(more)</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>(more)</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>o.m</u> <u>19</u> <u>19</u> <u>19</u> p.m. <u>19</u> <u>19</u> <u>19</u>					
20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>10-3-</u> <u>1961</u> to <u>11-1-</u> <u>1961</u> . that (I) (we) last saw the deceased alive on <u>10/27</u> <u>1961</u> and that death occurred at <u>12</u> <u>P.M.</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>J. P. Martin, M.D.</u>					
22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <u>J. P. Martin</u>					
22d. ADDRESS <u>Sandy Spring, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					
23b. DATE THEREOF <u>11/3/61</u>					
23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>					
23d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.-2901 14th St. N.W.</u>					
25a. REC'D BY REGISTRAR DATE <u>NOV 3 '61</u>					
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# STATE DEPARTMENT OF HEALTH

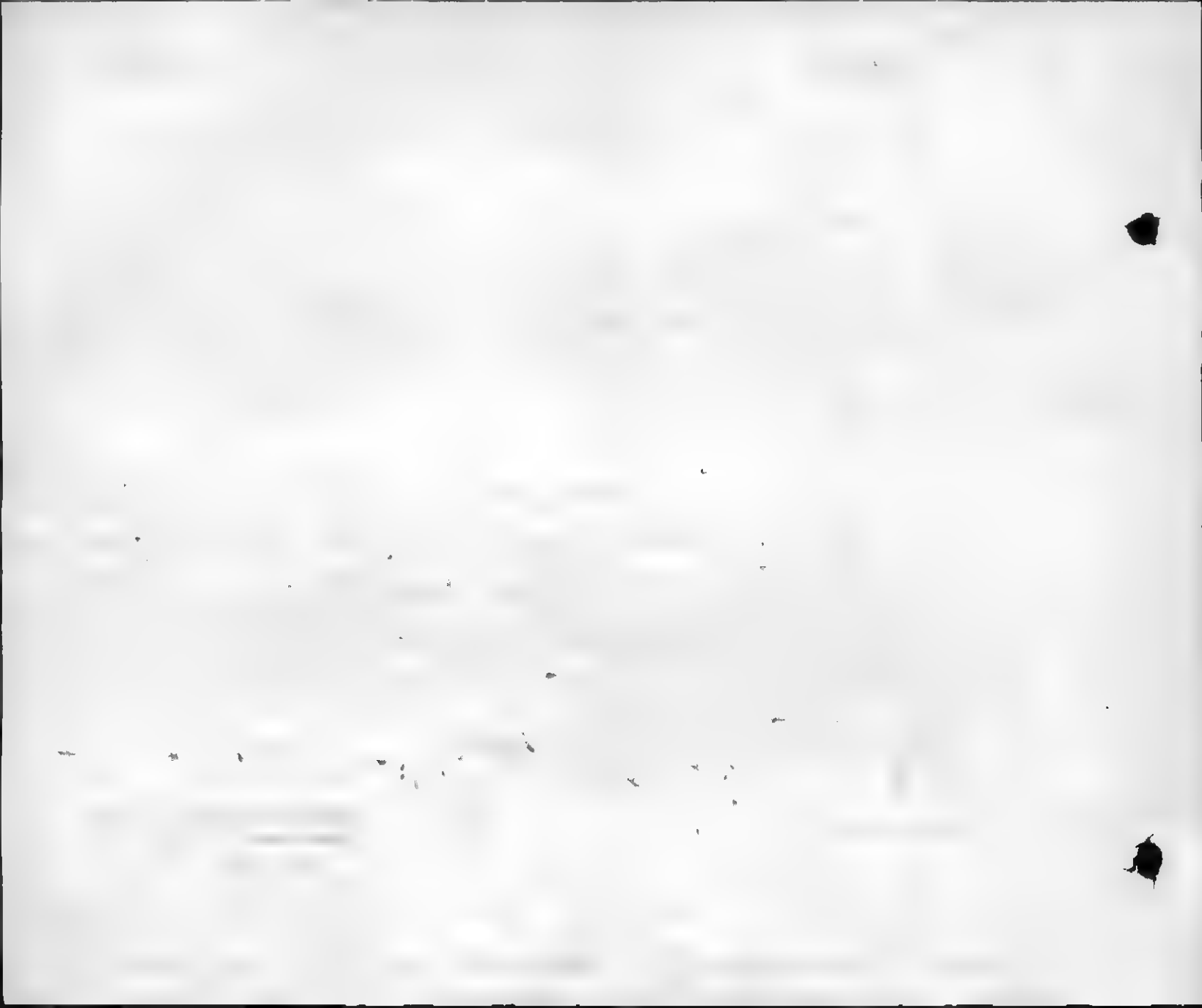
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12839

12325

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>4 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Hospital &amp; Medical Center</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>12411 31st</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>JOSEPH FRANK</u> First Middle Last <b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>10-5-01</u> <b>9. AGE</b> (In years last birthday) <u>51</u> yrs. IF UNDER 1 YEAR: Months <u>11</u> Days <u>11</u> IF UNDER 24 HRS.: Hours <u>19</u> Min. <u>01</u>	
<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>New York</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>United States</u>	
<b>13. FATHER'S NAME</b> <u>Helvin LeGrand</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Augusta Wilmon</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>	
<b>17. INFORMANT</b> <u>Hospital Records</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Cardiac Failure</u> <u>442X</u> DUE TO <u>Cardio-Vascular-Renal Syndrome</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <u>Cerebro-vascular accident.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e): <u>Right hemiplegia.</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>5 days</u>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
<b>20c. TIME OF INJURY</b> Month, Day, Year: Hour a.m. <u>19</u> p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		<b>20f. (City or town)</b> (County) (State) <u>Nov. 7, 1961</u> to <u>Nov. 11, 1961</u>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Nov. 10, 1961</u> , and that death occurred at <u>1:38 PM</u> , from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <u>Lynwood Heiges</u>		<b>22b. DATE SIGNED</b> <u>Nov. 10, 1961</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Lynwood Heiges</u>		<b>22d. ADDRESS</b> <u>6940 Piney Branch Road, N. W., Washington 12, D. C.</u>	
<b>23b. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u> <u>11/15/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>ALLEGHENY CO. MEM. PARK</u>	
<b>23d. LOCATION</b> (City, town or county) (State) <u>PITTSBURGH, PA.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>Charles S. Knease</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Real Funeral Home</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles S. Knease</u>	
<b>25c. ADDRESS</b> <u>4812 GAVE NW</u>		<b>25d. DATE</b> <u>NOV 16 '61</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12826

FOR STATE  
HEALTH DEPT.

**1. PLACE OF DEATH**

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY in 1b

Life

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

4307 Rosedale Ave

**2. USUAL RESIDENCE** (Where deceased lived, if last 1st on. Residence before admission)

e. STATE

md

b. COUNTY

montg

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

50 Bethesda

d. STREET ADDRESS

4307 Rosedale Ave

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

**3. NAME OF DECEASED**  
(Type or print)

Patricia Ann Kober

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

12-24-57

9. AGE (In years last birthday)

3 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

DE

12. CITIZEN OF WHAT COUNTRY?

U-S A

13. FATHER'S NAME

Edward B. Kober

14. MOTHER'S MAIDEN NAME

Helen Day

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Edw. B. Kober (father)

Address

**18. CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

587.3

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Asphyxiation  
Mucopurulent obstruction of bronchi  
(c) Pneumonia

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

INTERVAL BETWEEN ONSET AND DEATH

2 hrs

3 yrs

19. WAS AUTOPSY PERFORMED?

YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Hour a.m.

Month, Day, Year

p.m.

19

20d. INJURY OCCURRED

While at work ☐

Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from. Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Frank J. Broschant

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

11-30-61

EXAMINER'S NAME (Type)

FRANK J. BROSCANT

Address (Street, city, town, or county)

22d. LOCATION (City, town, or country)

(State)

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

12/2/61

22c. NAME OF CEMETERY OR CREMATORY

Gate of Heaven Cem.

22d. LOCATION (City, town, or country)

Silver Spring, Maryland

23. FUNERAL DIRECTOR

Robert A. Humphrey

ADDRESS

Bethesda, Maryland

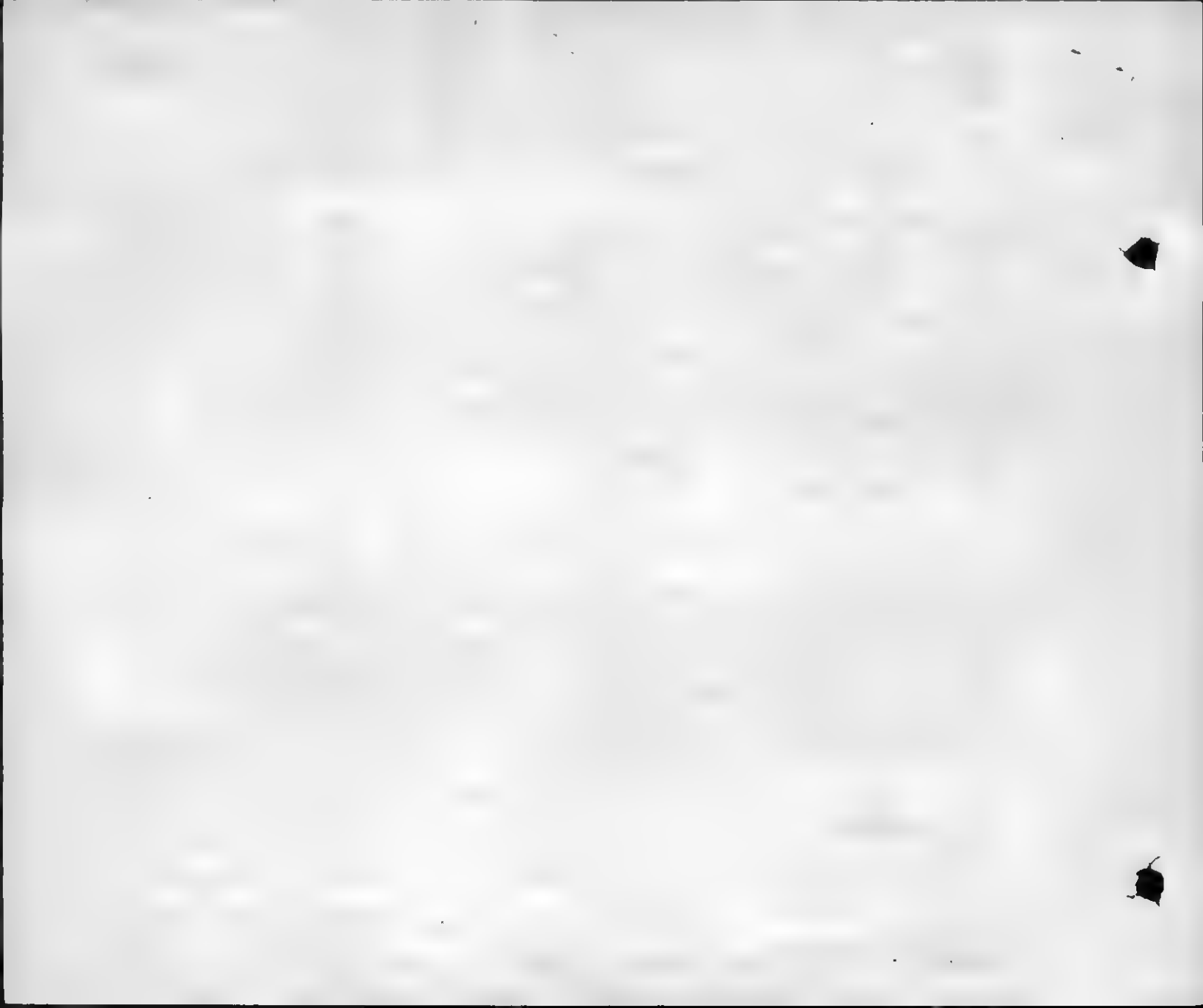
24a. REC'D BY REGISTRAR

DATE DEC 1 '61

24b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

TO DUTY MEDICAL EX: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, end in any event within 72 hours after death.



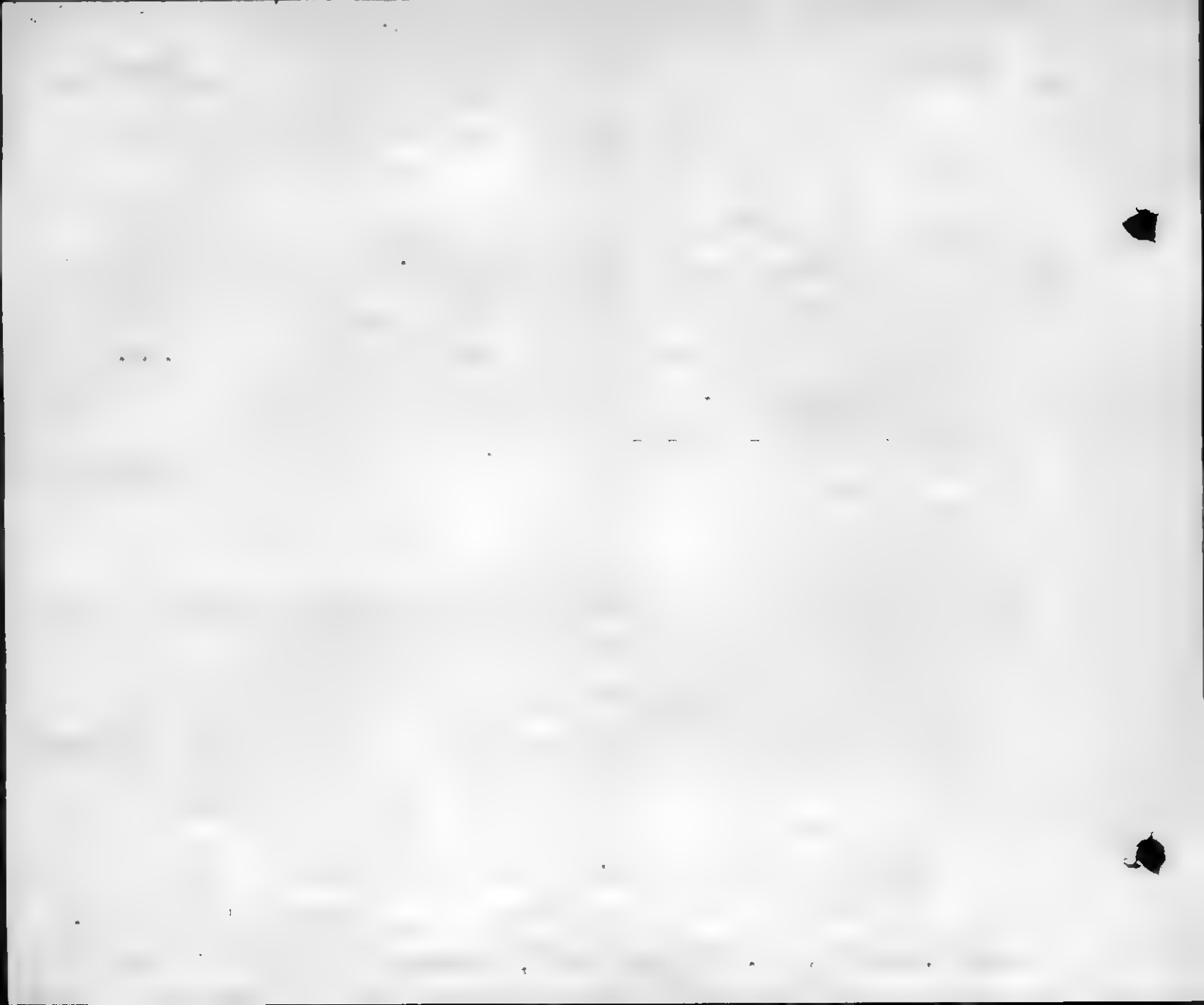
1  
FOR STATE  
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME  
5M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>				b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>				c. LENGTH OF STAY in lb <b>50 min.</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington San and Hosp</b>											
3. NAME OF DECEASED (Type or print) <b>Charles Edward Kraus Jr.</b>											
4. DATE OF DEATH Month <b>11</b> Day <b>16</b> Year <b>1961</b>											
5. SEX <b>male</b>											
6. COLOR OR RACE <b>white</b>											
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>											
8. DATE OF BIRTH <b>12/11/19</b>											
9. AGE (in years last birthday) <b>41</b> yrs											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Driver Sales</b>											
10b. KIND OF BUSINESS OR INDUSTRY <b>Thompson Dairy</b>											
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>											
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>											
13. FATHER'S NAME <b>Charles E. Kraus Sr.</b>											
14. MOTHER'S MAIDEN NAME <b>Clara Henretty</b>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>											
16. SOCIAL SECURITY NO. <b>579-05-8415</b>											
17. INFORMANT <b>Mrs. Charlotte Kraus</b>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RIGHT CEREBELLAR BRAIN TUMOR</b> 237 X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> Interval between onset and death <b>24 HRS.</b>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>11/16/61</b>											
ACTUAL SIGNATURE <b>Frank J. Broschart</b> EXAMINER'S NAME (Type) <b>Frank J. Broschart, M.D.</b> Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>											
22b. DATE THEREOF <b>11/8/61</b>											
22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>											
22d. LOCATION (City, town, or country) (State) <b>Prince George's County, Md.</b>											
23. FUNERAL DIRECTOR <b>Raymond A. Ziska</b> ADDRESS <b>434 GEORGIA AVENUE SILVER SPRING, MARYLAND</b>											
24a. REC'D BY REGISTRAR <b>NOV 20 '61</b>											
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12842

12828

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Derwood</u> d. STREET ADDRESS <u>Route #1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) <u>DORA</u>		<b>4. DATE OF DEATH</b> Month <u>11</u> Day <u>21</u> Year <u>1961</u>				
<b>5. SEX</b> <u>fe</u>		<b>6. COLOR OR RACE</b> <u>wh</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
<b>8. DATE OF BIRTH</b> <u>8-1-179</u>		<b>9. AGE</b> (In years last birthday) <u>82</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>—</u>		<b>11. BIRTHPLACE</b> (County & State or foreign country) <u>Unknown</u>		
<b>13. FATHER'S NAME</b> <u>Unknown</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service) <u>—</u>		<b>16. SOCIAL SECURITY NO.</b> <u>—</u>		<b>17. INFORMANT</b> Name <u>Mrs. Nancy Lea Smith</u> Address <u>AS ABOVE</u>		
<b>18. CAUSE OF DEATH</b> [Enter on one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Primary carcinoma of Liver</u> <u>155.0</u> DUE TO <u>(type ?)</u> Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (c) <u>  </u> DUE TO <u>  </u> cause last, stating the underlying cause last. (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):</b> <u>  </u>						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)						<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18) <u>  </u>
<b>20c. TIME OF INJURY</b> Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>		
<b>20f. [City or town]</b> <u>  </u>		<b>[County]</b> <u>  </u>		<b>[State]</b> <u>  </u>		
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>7/1/1961</u> <b>to</b> <u>11/21/1961</u> <b>that (I) (we) last saw the deceased alive on</b> <u>11/21/1961</u> <b>and that death occurred</b> <u>11/21/1961</u> <b>from the causes and on the date stated above.</b>						
<b>22a. SIGNATURE</b> <u>[Signature]</u>						<b>22b. DATE SIGNED</b> <u>11/21/61</u>
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>  </u>						<b>22d. ADDRESS</b> <u>  </u>
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>11/22/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Chattanooga, Tenn</u>		
<b>23d. LOCATION</b> (City, town or county) <u>Chattanooga, Tenn</u>		<b>[State]</b> <u>  </u>		<b>25a. REC'D BY REGISTRAR</b> <u>  </u>		
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Deed Funeral Home</u>		<b>ADDRESS</b> <u>4812 Ga Ave N.W.</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>  </u>		
<b>DATE</b> <u>NOV 29 '61</u>		<b>25c. REGISTRAR'S SIGNATURE</b> <u>  </u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

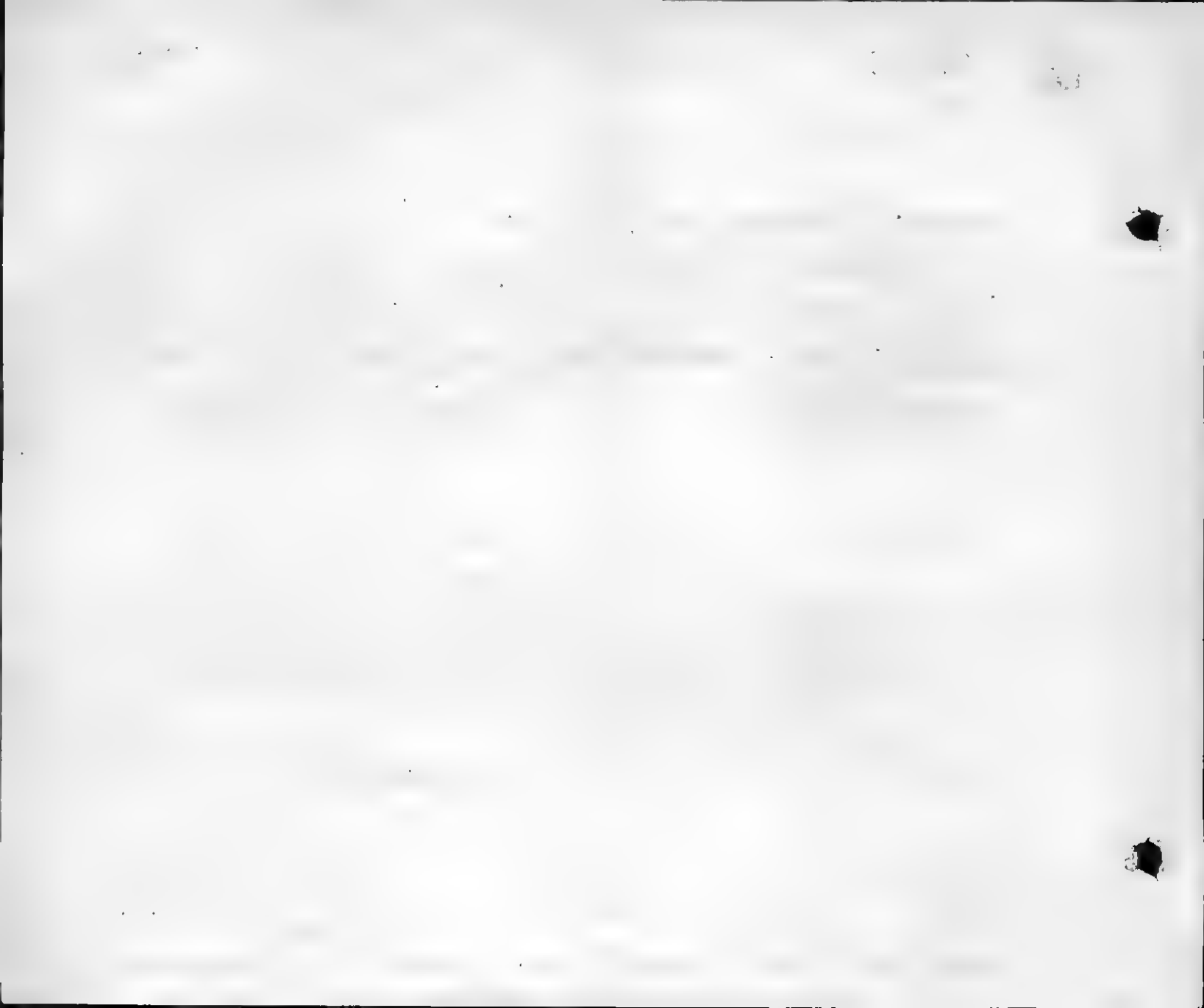
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12843

## CERTIFICATE OF DEATH

12829

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>6 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium + Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>6424 - 5th Ave</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Robert Brooke Leizear</u>		<b>4. DATE OF DEATH</b> Month <u>11</u> Day <u>18</u> Year <u>1961</u>		<b>5. IS RESIDENCE ON A FARM?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>6. SEX</b> <u>Male</u>		<b>7. COLOR OR RACE</b> <u>White</u>		<b>8. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>9. AGE</b> (In years last birthday) <u>81</u> yrs.		<b>10. DATE OF BIRTH</b> <u>7-12-80</u>		<b>11. AGE</b> (In years last birthday) <u>81</u> yrs.			
<b>12. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Seminary Caretaker</u>		<b>13. KIND OF BUSINESS OR INDUSTRY</b> <u>Rock Creek Cemetery</u>		<b>14. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>			
<b>15. FATHER'S NAME</b> <u>Louis Leizear</u>		<b>16. MOTHER'S NAME</b> <u>Rachael unknown</u>		<b>17. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>18. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		<b>19. SOCIAL SECURITY NO.</b> <u>377-01-0894</u>		<b>20. INFORMANT</b> <u>Mildred E. Byron Samaras #2 (daughter)</u>			
<b>21. CAUSE OF DEATH</b> (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO <u>Pneumonia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis generalized</u>		<b>22. INTERVAL BETWEEN ONSET AND DEATH</b> <u>4 hrs.</u>		<b>23. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>24a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>24b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II. of item 18.)					
<b>25a. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>25b. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>25c. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>26a. (City or town)</b>		<b>26b. (County)</b>		<b>26c. (State)</b>			
<b>27. I certify that (I) (this hospital) attended the deceased from <u>May 11-18-61</u> to <u>Nov. 18-61</u>, that (I) (we) last saw the deceased alive on <u>11-18-61</u>, and that death occurred at <u>10:30 PM</u> from the causes and on the date stated above.</b>							
<b>28a. SIGNATURE</b> <u>Aldo Vacca</u>		<b>28b. M.D.</b>		<b>28c. DATE SIGNED</b> <u>11-18-61</u>			
<b>28d. PHYSICIAN'S NAME</b> (Type) <u>ALDO VACCA</u>		<b>28e. ADDRESS</b> <u>1427 University Blvd, W. Silver Spring, Md.</u>					
<b>29a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>29b. DATE THEREOF</b> <u>11/21/61</u>		<b>29c. NAME OF CEMETERY OR CREMATORY</b> <u>Rock Creek</u>			
<b>29d. LOCATION</b> (City, town or county) <u>Washington D. C.</u>		<b>29e. (State)</b>					
<b>30. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Francis Gasch's Sons</u>		<b>30b. ADDRESS</b> <u>Hyattsville, Md.</u>		<b>30c. REC'D BY REGISTRAR</b> <u>NOV 21 '61</u>			
<b>30d. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>		<b>30e. DATE</b>					



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12830

1. PLACE OF DEATH  
a. COUNTY Montgomery County MARYLAND  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lieaton Md.  
c. LENGTH OF STAY IN 1b 83 days  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Bee Tree Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)  
a. STATE D.C.  
b. COUNTY Washington  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 2230-29th Pl, NW  
d. STREET ADDRESS 2230-29th Pl, NW  
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)  
First SARAH Middle C Last LEVENSON

4. DATE OF DEATH  
Month 11 Day 25 Year 1961

5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH AUG. 18 9-2  
WIDOWED ☒ DIVORCED ☐ 9. AGE (In years last birthday) 69 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None - HOUSEWIFE 10b. KIND OF BUSINESS OR INDUSTRY RUSSIA 11. BIRTHPLACE (County & State, or foreign country) U.S.A. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME UNKNOWN 14. MOTHER'S MAIDEN NAME UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO 16. SOCIAL SECURITY NO. --- 17. INFORMANT Address Mrs Sheldon WIKES 2500 Ross Rd. S.S.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Cerebral Thrombosis  
60 X DUE TO  
Conditions, if any, which gave rise to immediate cause (b) Cerebral arteriosclerosis  
(a), stating the underlying cause last (c) Diabetes Mellitus  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Parkinson's Disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While ☐ Not While ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5/2 19 61 to 11/26 1961, that (I) (we) last saw the deceased alive on 11/25 1961, and that death occurred at 4:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE Max G. Sherer M.D. 22b. DATE SIGNED 11/26  
22c. PHYSICIAN'S NAME (Type) MAX SHERER, M.D. 22d. ADDRESS 2025 EAST WEST Hwy Silver Spring, Md

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF NOV. 27, 1961 23c. NAME OF CEMETERY OR CREMATORY MT. LEBANON CEMETERY 23d. LOCATION (City, town or county) (State) HYATTSVILLE MD.

24. FUNERAL DIRECTOR'S SIGNATURE B. D. Dargatzis ADDRESS 3521-14th St NW 25a. REC'D BY REGISTRAR DATE NOV 28 '61 25b. REGISTRAR'S SIGNATURE Arthur L. Kincaid

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

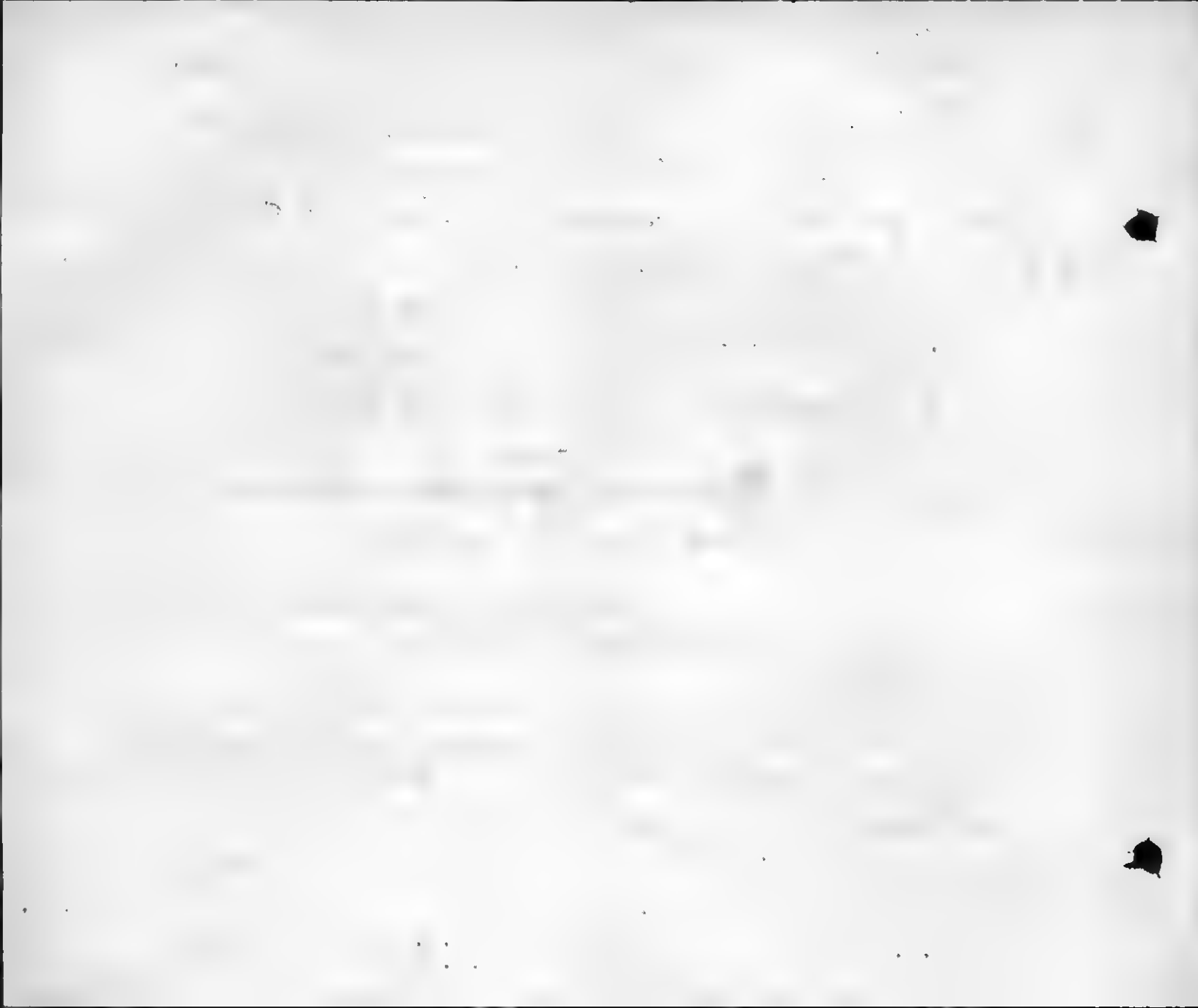
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12845

## CERTIFICATE OF DEATH

12831

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN (b) <u>2 wks</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Saniterium + Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>222 Farragut St. N.W.</u> d. STREET ADDRESS <u>222 Farragut St. N.W.</u>											
<b>3. NAME OF DECEASED</b> (Type or print) <u>Stella Ruth Lewis</u>				<b>4. DATE OF DEATH</b> Month <u>November</u> Day <u>26</u> Year <u>1961</u>											
<b>5. SEX</b> <u>Female</u>				<b>6. COLOR OR RACE</b> <u>White</u>											
<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>				<b>8. DATE OF BIRTH</b> <u>2-23-83</u>											
<b>9. AGE</b> (In years last birthday) <u>78</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>				IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of work life, if any) <u>Dept. of Commerce</u>			
IF UNDER 1 YEAR		IF UNDER 24 HRS.													
Months	Days	Hours	Min.												
<b>11. BIRTHPLACE</b> (County & State or foreign country) <u>Missouri</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b>											
<b>13. FATHER'S NAME</b> <u>John Louis</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Charlotte Veazie</u>											
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>				<b>16. SOCIAL SECURITY NO</b> <u>?</u>											
<b>17. INFORMANT</b> <u>Hosp. records</u>				<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Thrombosis left internal carotid artery</u> DUE TO (b) <u>Cerebral arterio-sclerosis</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.											
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				<b>20. INTERVAL BETWEEN ONSET AND DEATH</b> <u>1 week 25 yrs</u>											
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>Hypertensive heart disease</u>															
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING TO CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18)											
<b>20c. TIME OF INJURY</b> Hour <u>19</u> e.m. p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)									
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>11/12</u> , 19 <u>61</u> <b>to</b> <u>11/26</u> , 19 <u>61</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>11/26</u> , 19 <u>61</u> , <b>and that death occurred at</b> <u>4P</u> M., <b>from the causes and on the date stated above.</b>															
<b>22a. SIGNATURE</b> <u>Samuel M. Bageant</u> M.D.				<b>22b. DATE SIGNED</b>											
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Samuel M. Bageant</u>				<b>22d. ADDRESS</b> <u>5600 N.H. Ave Wash., D.C.</u>											
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>burial</u>		<b>23b. DATE THEREOF</b> <u>11/29/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Ft. Lincoln Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Prince Georges County, Md.</u>									
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>The S.H. Hines Company</u>				<b>25. REC'D BY REGISTRAR</b> <u>NOV 28 '61</u>											
<b>25a. ADDRESS</b> <u>2901 14th St/ N. Washington, D.C.</u>				<b>25b. REGISTRAR'S SIGNATURE</b> <u>Conroy L. Turner</u>											



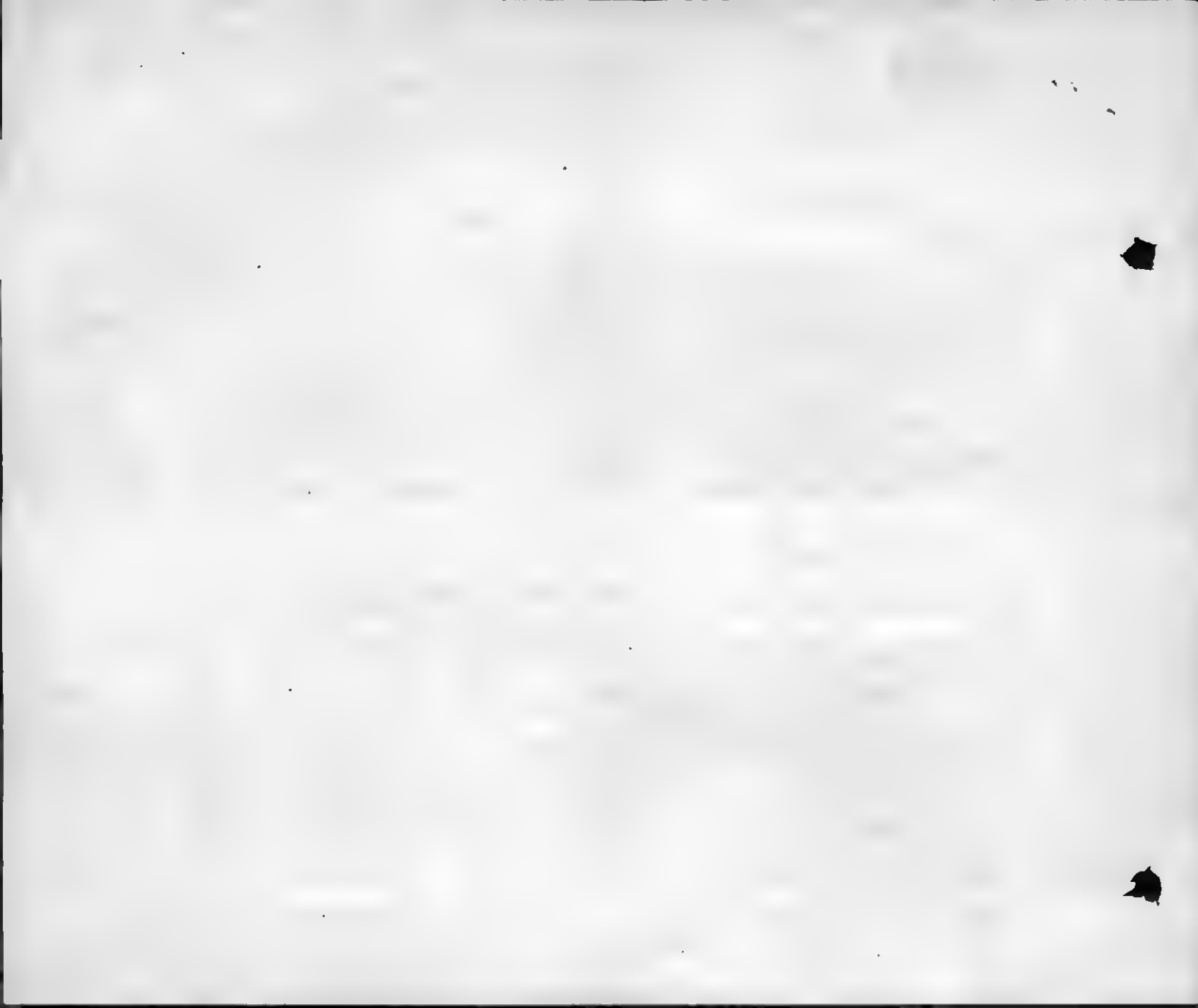
**DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS, A15ME  
SM 9/60

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**TICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** **12832**

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admn ssion) e. STATE <b>MARYLAND</b>		b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. LENGTH OF STAY IN 1b <b>20 mins.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SUBURBAN Hospital</b>		d. STREET ADDRESS <b>7009 AMY LANE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Roy</b>		First <b>Philip</b>		Middle <b>LITKE</b>	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>MAY 31, 1927</b>		9. AGE (In years last birthday) <b>34</b> yrs.		10. IF UNDER 1 YEAR Months Days <b>NOV. 23 1961</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>C.I.A.</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Oregon</b>	
13. FATHER'S NAME <b>Philip Littke</b>		14. MOTHER'S MARDEN NAME <b>Leta Stillman</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.C.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW 2 544-24-4224</b>		17. INFORMANT <b>Police Record</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>976 X</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>gun shot wound</b> (c) <b>Head practically decapitated</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Was a mental pt on leave from St. Eliz Hosp</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Self-inflicted gun shot wound</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year <b>12:45 p.m. 11-23 1961</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
20f. (City or town) <b>Bethesda</b>		20g. (County) <b>Montgomery</b>		20h. (State) <b>MD</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Frank J. Brochart</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>11-23-61</b>	
EXAMINER'S NAME (Type) <b>Frank J. Brochart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/27/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Cemetery</b>	
22d. LOCATION (City, town, or country) <b>Arlington, Virginia</b>		22e. REC'D BY REGISTRAR <b>NOV 30 '61</b>		22f. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	
23. FUNERAL DIRECTOR <b>Robert A. Pumphrey, Bethesda, Maryland</b>					



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

1  
FOR STATE  
HEALTH DEPT.

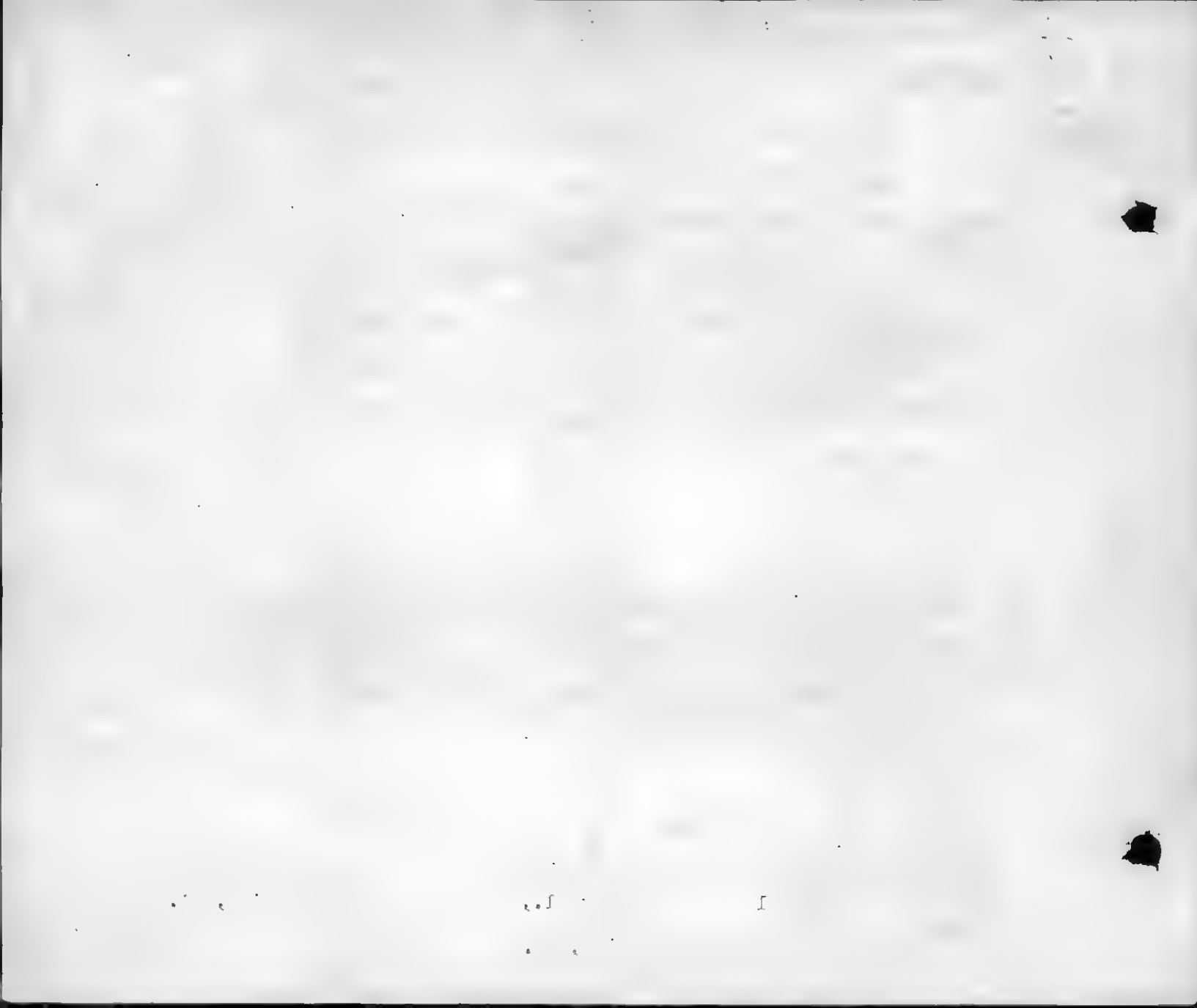
1  
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12833

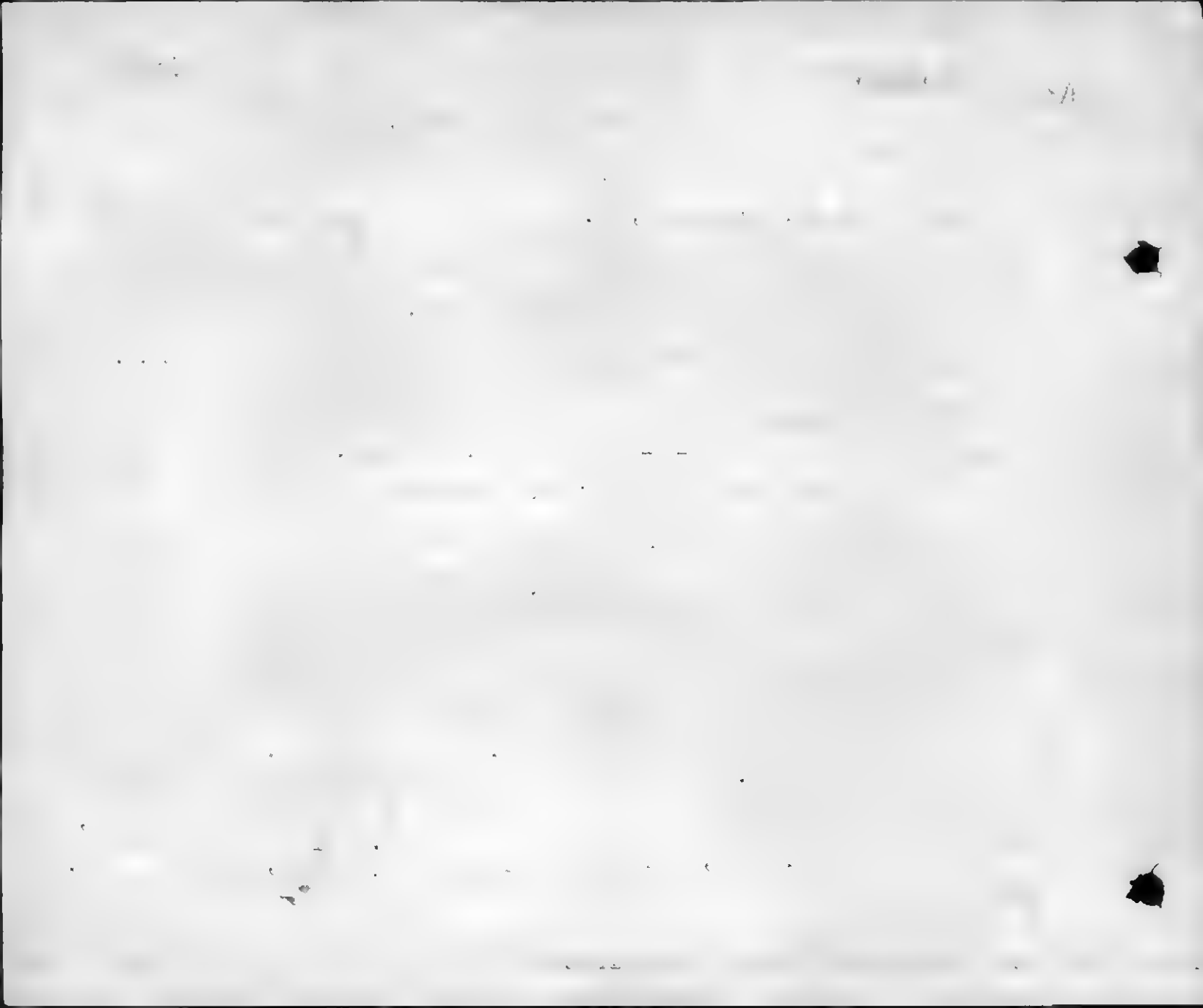
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sandy Spring</u> <u>3 yrs</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>13 Sandy Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Brook Road</u>		d. STREET ADDRESS <u>1 Brook Road</u>	
3. NAME OF DECEASED (Type or print) <u>Nellie Lynn</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>17</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (in years last birthday) <u>57</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joe. Lynn</u>		14. MOTHER'S MAIDEN NAME <u>Mary Carter</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>Rosie Afford -</u>	
17. INFORMANT <u>Itum 2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Found dead in bed</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/20/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial.</u>		22d. LOCATION (City, town, or country) (State) <u>Sandy Spring, Md.</u>	
23. FUNERAL DIRECTOR <u>Robert L. Suorden</u>		ADDRESS <u>Rockville, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>NOV 24 '61</u>		24b. REGISTRAR'S SIGNATURE <u>O. L. L. L.</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
12848 Item 6 Film G302 12/18/61 jwk 12834											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>90 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>New Jersey</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bellmawr</u> d. STREET ADDRESS <u>19 Apple Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Frank Leroy MacCrea</u>		4. DATE OF DEATH <u>November 17 1961</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 23, 1907</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Not employed</u>		11. BIRTHPLACE (County & State, or foreign country) <u>New Jersey</u>		9. AGE (In years last birthday) <u>54 yrs.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>James MacCrea</u>				14. MOTHER'S MAIDEN NAME <u>Bertha Capwell</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>148-07-6969</u>				17. INFORMANT <u>The Medical Record</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mycosis fungoides, extensive</u> DUE TO (b) <u>Pneumonia, Left upper lobe</u> DUE TO (c) <u>Multiple abscesses, colon</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e): <u>3 days</u> <u>3 days</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) <u>Bellmawr N.J.</u>				20g. (County) <u>Bellmawr N.J.</u>				20h. (State) <u>N.J.</u>			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Aug. 19, 1961</u> , to <u>Nov. 17, 1961</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Nov. 17, 1961</u> , and that death occurred at <u>5:40 AM</u> on the causes and on the date stated above.											
22a. SIGNATURE <u>John C. Marsh</u>				22b. DATE SIGNED <u>November 17, 1961</u>				22c. PHYSICIAN'S NAME (Type) <u>John C. Marsh, M.D.</u>			
22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>				22e. REC'D BY REGISTRAR <u>W.W. Chambers Co. Washington D.C.</u>				22f. REGISTRAR'S SIGNATURE <u>William S. Hume</u>			
23a. BURIAL, CREMATION, REMOVAL <u>BURIAL</u>				23b. DATE THEREOF <u>11/17/61</u>				23c. NAME OF CEMETERY OR CREMATORY <u>BELLMAWR N.T.</u>			
23d. LOCATION (City, town or county) <u>Bellmawr N.J.</u>				23e. LOCATION (State) <u>N.J.</u>				23f. LOCATION (Country) <u>U.S.A.</u>			



## CERTIFICATE OF DEATH

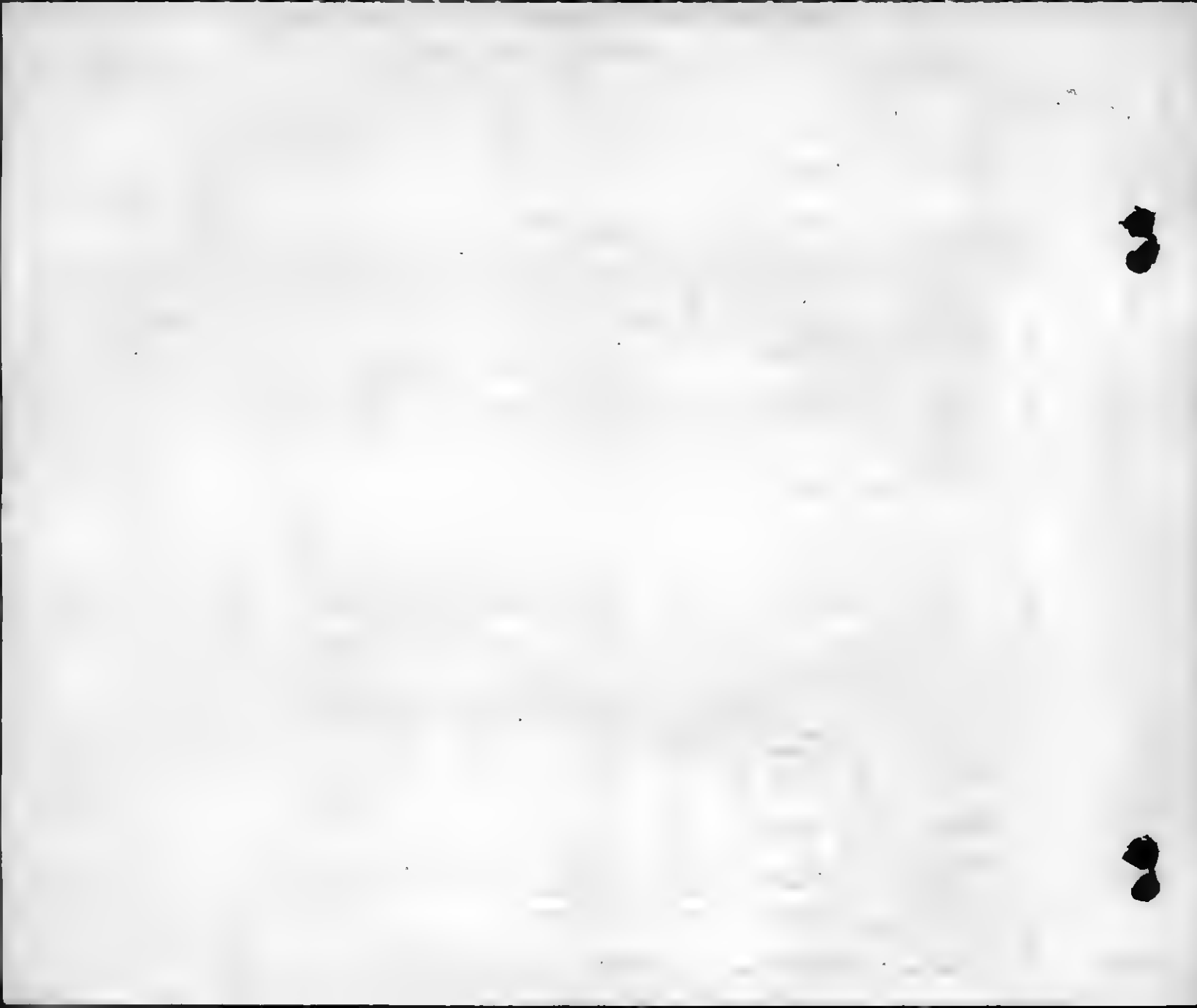
Reg. Dist. No. 12835

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Laytonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Laytonsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Riggs Rd.</b>		d. STREET ADDRESS <b>Riggs Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>ANGUS</b> Middle <b>(none)</b> Last <b>MACLEAN</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>2</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Wh.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 16, 1871</b>
9. AGE (In years last birthday) <b>90</b> yrs		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>business - automotive</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Automotive</b>	
11. BIRTHPLACE (State or foreign country) <b>Canada</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Murdoch MacLean</b>		14. MOTHER'S MAIDEN NAME <b>unknown.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>380-22-2865</b>	
17. INFORMANT <b>Mrs. Ray Roberts</b> Address <b>Derwood, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> DUE TO <b>Congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>2 yrs.</b> <b>3 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1953</b> to <b>Nov 2</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>Oct 31</b> , 19 <b>61</b> , and that death occurred at <b>7:00 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Richard A. Yates</b> M.D.		ADDRESS (Street, city or town, state) <b>Olney, Md</b> DATE SIGNED <b>11/2/61</b>	
PHYSICIAN'S NAME (Type) <b>Richard A. YATES</b>		<b>Olney, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/4/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b> ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>NOV 6 '61</b> DATE	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



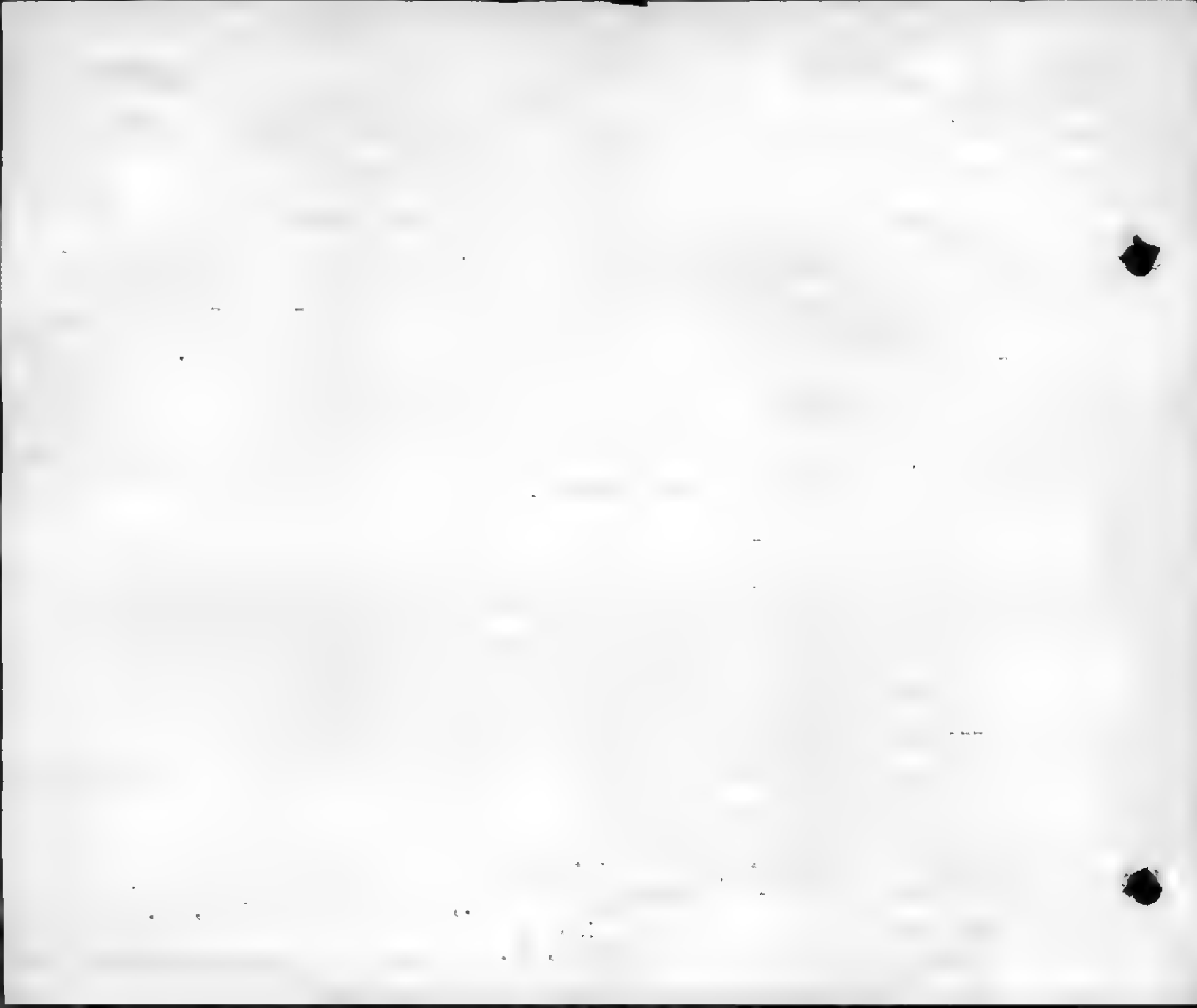
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or in any event within 72 hours after death.

VR A15 (4)  
15M 7'61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
12850														
12836														
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b> c. LENGTH OF STAY IN 1b <b>2 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MONTGOMERY GENERAL HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HOWARD</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELLICOTT CITY</b> d. STREET ADDRESS <b>51 MERRYMAN STREET</b>									
3. NAME OF DECEASED (Type or print) <b>MELVIN</b> First <b>EUGENE</b> Middle <b>MAKLE</b> Last					4. DATE OF DEATH Month <b>11</b> Day <b>22</b> Year <b>19 61</b>									
5. SEX <b>MALE</b>					6. COLOR OR RACE <b>COLORED</b>					7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				
8. DATE OF BIRTH <b>11/20/61</b>					9. AGE (In years last birthday) <b>2</b> yrs. <b>2</b> months <b>2</b> days					10. IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (County & State, or foreign country) <b>MONTGOMERY, MARYLAND</b>				
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					13. FATHER'S NAME <b>RAYMOND WILLIAM MAKLE</b>					14. MOTHER'S MAIDEN NAME <b>LAURA VIRGINIA DORSEY</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>					16. SOCIAL SECURITY NO.					17. INFORMANT <b>HOSPITAL RECORDS</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HYPOPROTHROMBINEMIA, CONGENITAL.</b> 771.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) - (a), stating the underlying cause last. DUE TO (c) - PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										INTERVAL BETWEEN ONSET AND DEATH				
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>										20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>11/20/61</b> to <b>11/22/61</b> , that (I) (we) last saw the deceased alive on <b>11/22/61</b> , and that death occurred at <b>11:45P</b> M, from the causes and on the date stated above.										22a. SIGNATURE <b>Charles S. Whitaker</b> M.D. 22b. DATE SIGNED <b>NOV 20 1961</b>				
22c. PHYSICIAN'S NAME (Type) <b>CHARLES S. WHITAKER, M.D.</b>										22d. ADDRESS <b>CAARKSVILLE, MARYLAND</b>				
23a. BURIAL, CREMATION REMOVAL <b>Burial</b>										23b. DATE THEREOF <b>11/25/61</b>				
23c. NAME OF CEMETERY OR CREMATORY <b>Locust Methodist.</b>										23d. LOCATION (City, town or county) (State) <b>Simpsonville, Md.</b>				
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Snowden</b> ADDRESS <b>Rockville, Md.</b>										25a. REC'D BY REGISTRAR DATE <b>NOV 20 1961</b>				
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Haines</b>														

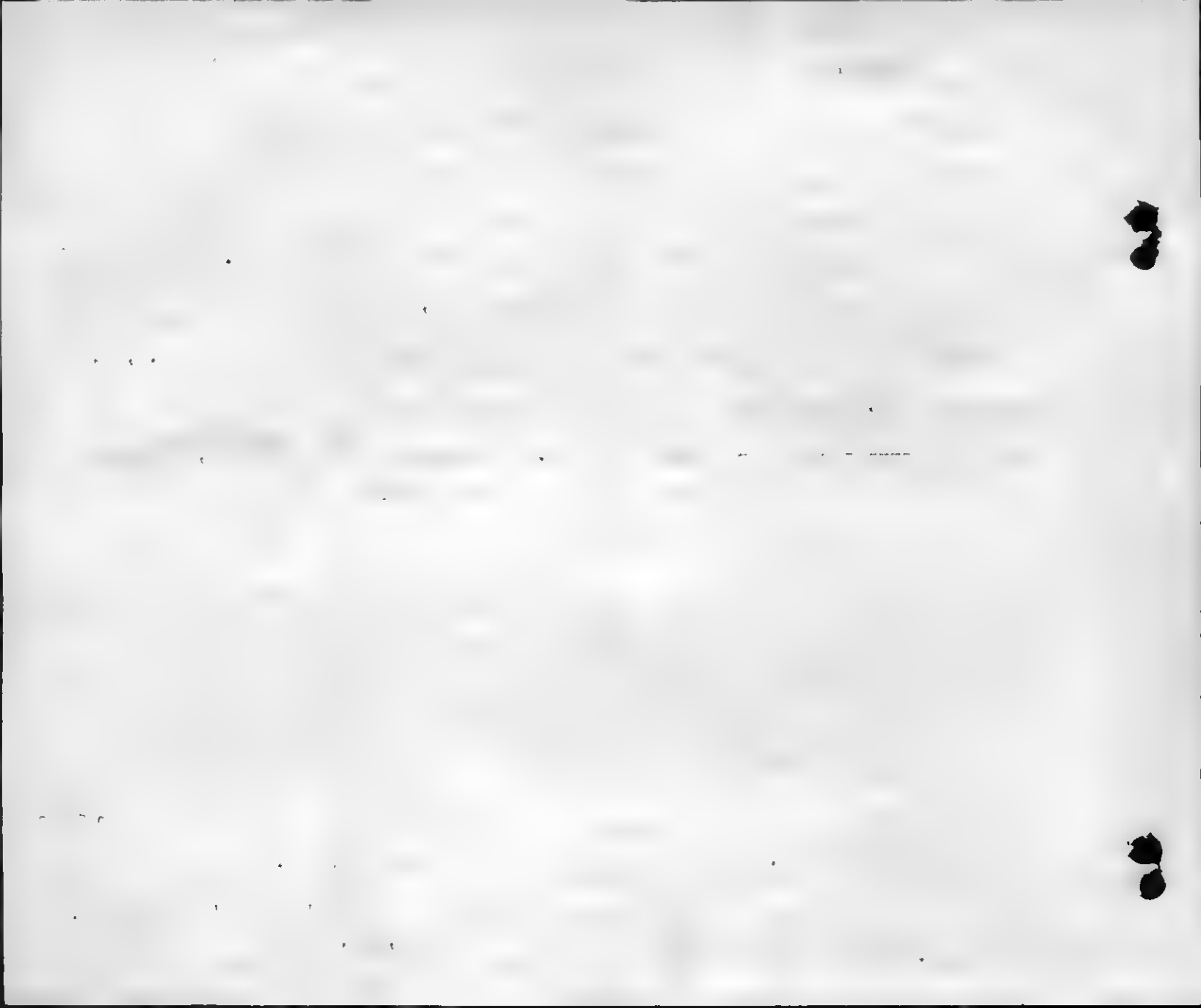
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completed. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Michigan</b>				b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Germantown</b>				c. LENGTH OF STAY IN 1b <b>2 years</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Royal Oak</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Marylander Nursing Home</b>				d. STREET ADDRESS <b>1st Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Grace Gertrude Martin</b>				4. DATE OF DEATH Month Day Year <b>Nov. 16 19 61</b>							
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 29, 1879</b>		9. AGE (In years last birthday) <b>81 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>				11. BIRTHPLACE (County & State or foreign country) <b>Pennsylvania</b>			
13. FATHER'S NAME <b>Norman W. Hine</b>				14. MOTHER'S MAIDEN NAME <b>Laura Fletcher</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO <b>None</b>				17. ADDRESS <b>Mr. David Bishop 2605 Elmont Street Silver Spring, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>412.1 Arteriosclerotic cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (b) <b>16 years</b> (a), stating the underlying cause last. (c) <b>16 years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>412.1</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <b>16 years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)											
21. I certify that (I) (the hospital) attended the deceased from <b>Nov. 10, 1960</b> to <b>Nov. 16, 1960</b> , that (I) <b>did</b> last saw the deceased alive on <b>Nov. 15, 1960</b> , and that death occurred at <b>11:16</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>James P. Kerr</b>				22b. DATE SIGNED <b>11/16/61</b>							
22c. PHYSICIAN'S NAME (Type) <b>James P. Kerr</b>				22d. ADDRESS <b>Damascus, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>				23b. DATE THEREOF <b>11/17/61</b>				23c. NAME OF CEMETERY OR CREMATORY <b>FORT LINCOLN CREMATORY</b>			
23d. LOCATION (City, town or county) (State) <b>PRINCE GEORGE'S COUNTY MD.</b>											
24. FUNERAL DIRECTOR'S SIGNATURE <b>Warner J. Pumphrey</b>				24b. ADDRESS <b>3034 Georgia Avenue, Silver Spring, Md.</b>				25. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			
25a. DATE <b>NOV 20 1961</b>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

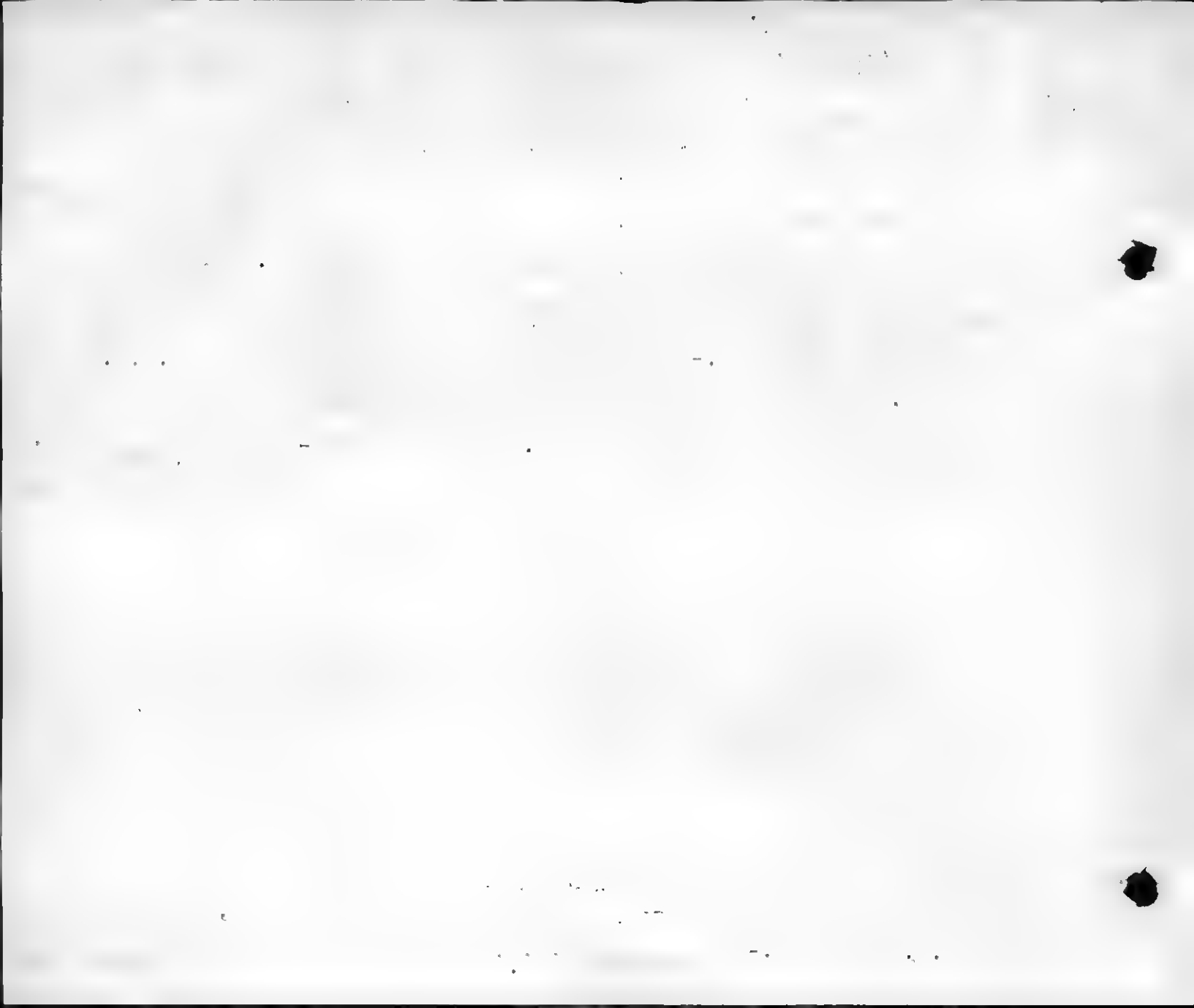
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12852

## CERTIFICATE OF DEATH

12838

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN b <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>45 Bethesda</b> d. STREET ADDRESS <b>6201 Green Tree Road</b>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>6201 Green Tree Road</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>GLADYS A McALLISTER</b>			4. DATE OF DEATH <b>Nov. 24, 1961</b>		
5. SEX <b>Female</b>			6. COLOR OR RACE <b>White</b>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>1/25/1887</b>		
9. AGE (In years last birthday) <b>74</b> yrs.			10. IF UNDER 1 YEAR Months Days		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chief Operator-Tel. Co., -in Nebraska</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Illinois</b>		
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>John A. Peugh</b>			14. MOTHER'S MAIDEN NAME <b>Minnie Hurlbutt</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16. SOCIAL SECURITY NO. <b>505-07-0467</b>		
17. INFORMANT <b>G. Belva Anderson</b>			Address <b>6201 Green Tree Rd. Bethesda, Maryland</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 PROBABLE MYOCARDIAL INFARCTION 2 HRS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b>					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that (I) (the hospital) attended the deceased from <b>10-23-1961</b> to <b>11-24-1961</b> that (I) (the) last saw the deceased alive on <b>11-23-1961</b> , and that death occurred at <b>11 AM</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>Edward Lewis Jr. M.D.</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>11-24-61</b>					
22c. PHYSICIAN'S NAME (Type) <b>EDWARD LEWIS, JR. M.D.</b> 22d. ADDRESS <b>5800 BEECH AVE, BETHESDA, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b> 23b. DATE THEREOF <b>11/27/1961</b> 23c. NAME OF CEMETERY OR CREMATORY <b>--</b> 23d. LOCATION (City, town or county) (State) <b>Litchfield, Nebraska</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co. - 2901 14th St. N.W. Washington 9, D.C.</b> ADDRESS <b>Washington 9, D.C.</b> 25a. REC'D BY REGISTRAR <b>NOV 27 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completed and signed by the funeral director. After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

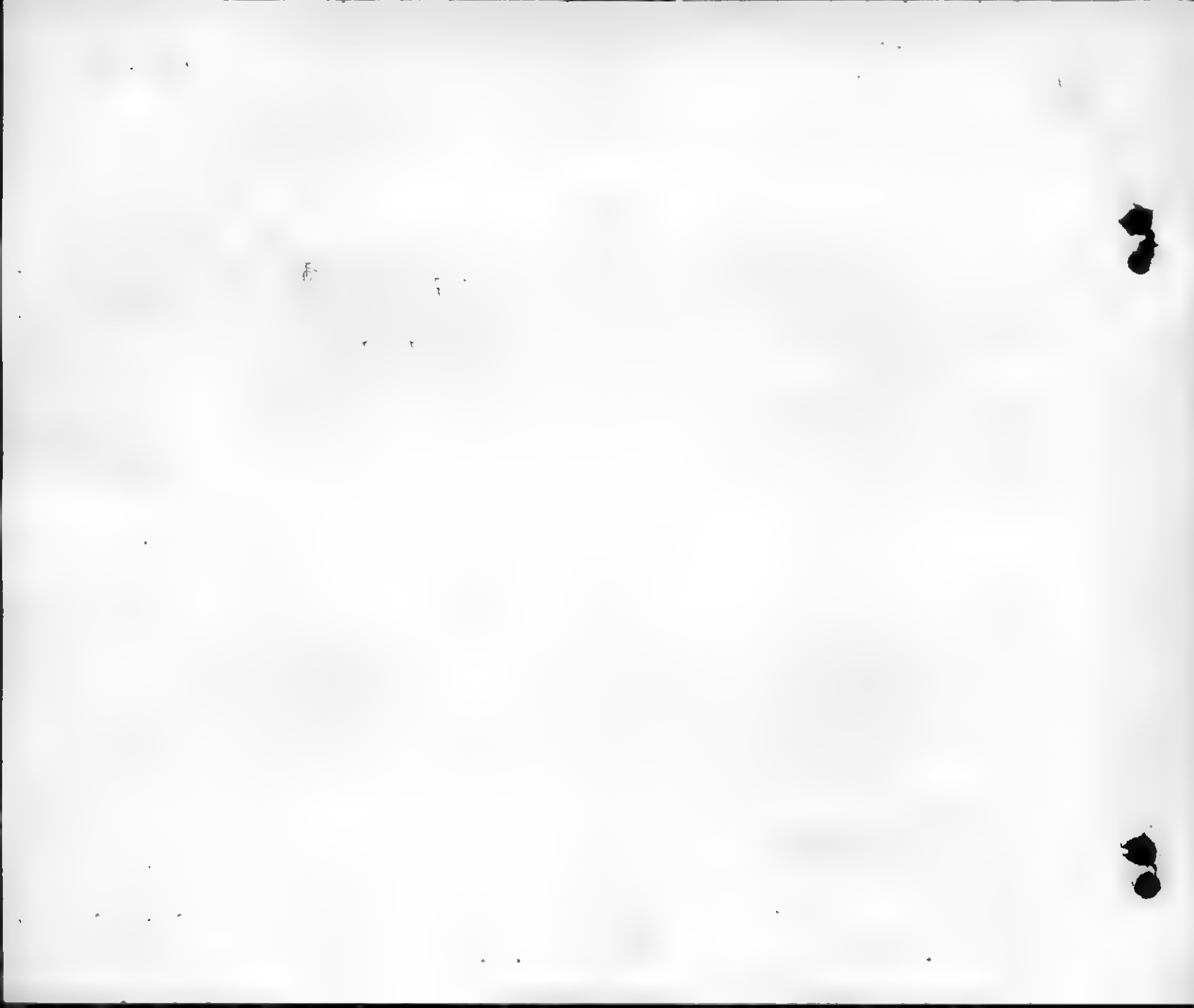
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12853

12839

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY in lb <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Stafford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Virginia Beach</u> d. STREET ADDRESS <u>177 Pinewood Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Clara</u> <u>Wilhelmina McCully</u>		<b>4. DATE OF DEATH</b> <u>November 17 1961</u>	
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>white</u>	
<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>MARCH 28 1900</u>	
<b>9. AGE</b> (In years last birthday) <u>61</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Norfolk, VA</u>	
<b>13. FATHER'S NAME</b> <u>Max Moser</u>		<b>14. MOTHER'S M.A.DEN NAME</b> <u>Clara Hutchsteiner</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (b) <u>4-20.1</u> (a), stating the underlying cause last. <u>4-20.1</u> DUE TO (c) <u>4-20.1</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>American</u>	
<b>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>19</u> a.m. <u>19</u> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Nov 14</u> , 1961, to <u>Nov 17</u> , 1961, that (I) (we) last saw the deceased alive on <u>Nov 16</u> , 1961, and that death occurred about <u>6:00</u> A.M. from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <u>W.B. Wardrop MD</u>		<b>22b. DATE SIGNED</b> <u>11/17/61</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>W.B. WARDROP MD</u>		<b>22d. ADDRESS</b> <u>800 S. Church St. Prince George's Co. Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Cremation</u>		<b>23b. DATE THEREOF</b> <u>Nov 18, 1961</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Fort Lincoln Crematory</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Prince George Co. Md.</u>	
<b>24. FUNERAL HOME'S SIGNATURE</b> <u>Warner E. Pumphrey Inc</u>		<b>24. ADDRESS</b> <u>8434 Georgia Ave Sil. Sp. Md</u>	
<b>25a. REC'D BY REGISTRAR</b> <u>Nov 22 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hanna</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

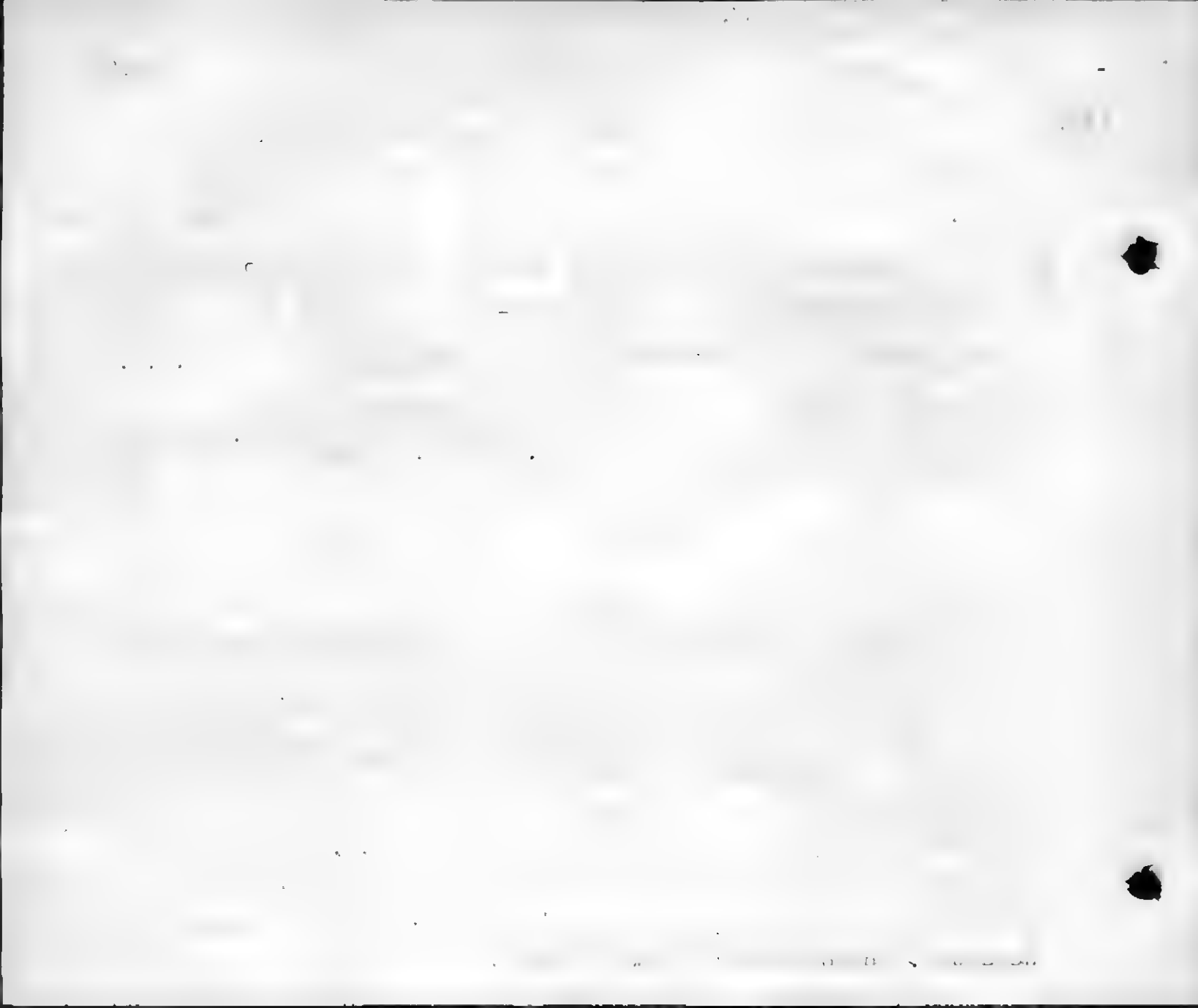
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12854

12840

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>83X 2</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Falls Church</b>	
c. LENGTH OF STAY IN 1b <b>4 days</b>		d. STREET ADDRESS <b>6400 Glen Forest Drive</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Patrick Henry Mc Grath</b>		4. DATE OF DEATH <b>November 21 19 61</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-2-70</b>	
9. AGE (In years last birthday) <b>91</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Mc Grath</b>		14. MOTHER'S MAIDEN NAME <b>Anastasia Dooley</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>6400 Glen Forest Dr. Falls Church</b>	
17. INFORMANT <b>Mrs. Mary C. McGrath, Virginia</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a). <b>Respiratory Failure</b> 332 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Cerebro-Vascular Thrombosis</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Previous episodes of Cerebro-Vascular Thrombosis</b>	
19. INTERVAL BETWEEN ONSET AND DEATH <b>48-72 hrs</b>		20. INTERVAL BETWEEN ONSET AND DEATH <b>48-72 hrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>November 18 1961</b> to <b>November 21 1961</b> (X) (we) last saw the deceased alive on <b>November 21 19 61</b> and that death occurred at <b>4:00 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>William A. Rack</b> M.D.		22b. DATE SIGNED <b>November 22, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>William A Rack LT MC USN</b>		22d. ADDRESS <b>U.S. NAVAL HOSPITAL Bethesda, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-24 61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Memorial Park</b>		23d. LOCATION (City, town or county) (State) <b>Fairfax, Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert F. Murphy</b>		25a. REC'D BY REGISTRAR <b>DATE NOV 27 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Carroll S. Jones</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

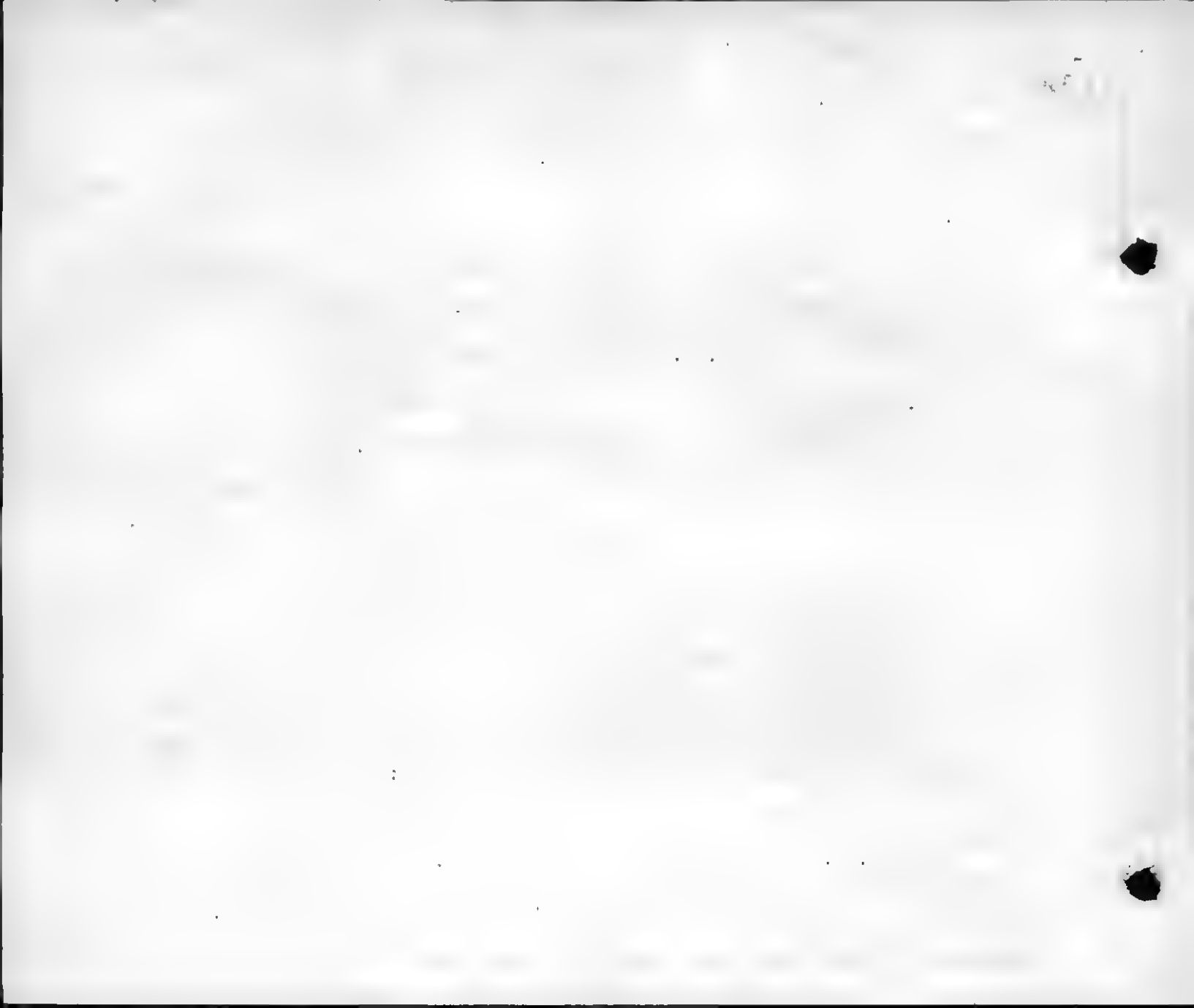
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12855

12841

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN <u>65</u> days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Alexandria</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Alexandria</u> d. STREET ADDRESS <u>30 Ancell Street</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Kenneth</u> <u>(n)</u> <u>McKay</u> S. SEX <u>Male</u> 6. COLOR OR RACE <u>Caucasian</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Armed Forces</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Navy</u>		4. DATE OF DEATH <u>November 21, 1961</u> 5. DATE OF BIRTH <u>September 22, 1913</u> 9. AGE (in years last birthday) <u>48</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Massachusetts</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harry W. McKay</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW II Korea</u> 16. SOCIAL SECURITY NO. <u>017 03 8017</u>		14. MOTHER'S MAIDEN NAME <u>Louise Loud</u> 17. INFORMANT <u>WIFE: Elizabeth S. McKay, Same as 12</u> Address <u>12</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma involving large bowel</u> Conditions, if any, which gave rise to immediate cause (b) <u>with bowel obstruction &amp; hemorrhage</u> (c) <u>Carcinoma Kidney</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>2 weeks</u> <u>2 yrs</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year <u>Sept. 18, 1961</u> to <u>Nov. 21, 1961</u> Hour a.m. <u>12:31</u> p.m. <u>44</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>U. S. Naval Hospital, Bethesda, Md.</u> 20f. (City or town) <u>Arlington, Va.</u> (County) <u>Arlington</u> (State) <u>Va.</u>	
21. I certify that <u>14</u> (this hospital) attended the deceased from <u>Sept. 18, 1961</u> to <u>Nov. 21, 1961</u> , that <u>(X)</u> (we) last saw the deceased alive on <u>Nov. 21, 1961</u> , and that death occurred at <u>12:31</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>H. S. Irons</u> M.D. <u>11-24-61</u> 22c. PHYSICIAN'S NAME (Type) <u>H. S. IRONS LT MC USN</u>		22b. DATE SIGNED <u>November 21 1961</u> 22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>11-24-61</u> 24. FUNERAL DIRECTOR'S SIGNATURE <u>Alfred F. Bunker</u> ADDRESS <u>Alexandria, Va.</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u> 23d. LOCATION (City, town or county) <u>Arlington, Va.</u> (State) <u>Va.</u> 25a. REC'D BY REGISTRAR <u>Alfred F. Bunker</u> 25b. REGISTRAR'S SIGNATURE <u>Alfred F. Bunker</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completed, filled in by the funeral director. After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12842

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>29 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San &amp; Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Rockville</u> d. STREET ADDRESS <u>13415 Carroll Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Mr. Norman Elmer McKenzie</u>		4. DATE OF DEATH Month <u>11</u> Day <u>26</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-29-06</u>
9. AGE (In years last birthday) <u>55</u> yrs		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>26</u> Hours <u>11</u> Min. <u>26</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabinet Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Contempo Assoc</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Noah McKenzie</u>		14. MOTHER'S MAIDEN NAME <u>Inez Minnick</u>	
15. WAS DECEASED EVER U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Hospital Records</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>18 days</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>578X</u> DUE TO <u>Pulmonary Embolism</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Surgery - Resection of Rectum</u> (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>18 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> e.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 35, 1961</u> , to <u>Nov 26, 1961</u> , that (I) (we) last saw the deceased alive on <u>Nov 26, 1961</u> , and that death occurred at <u>12:00 P.M.</u> from the causes and on the date stated above			
22a. SIGNATURE <u>Robert A. Hare</u> M.D.		22b. DATE SIGNED <u>11/26/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert A. Hare M.D.</u>		22d. ADDRESS <u>7600 Carroll Ave T. Park Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11/30/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ST MICHAEL'S</u>		23d. LOCATION (City, town or county) (State) <u>FROSTBURG MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Don Newman, Grantsville, MD</u>		25a. REC'D BY REGISTRAR <u>DEC 4 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>		25c. DATE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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2

MEDICAL CERTIFICATION

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**12857** **CERTIFICATE OF DEATH** **12843**

1. PLACE OF DEATH  
a. COUNTY **Montgomery** MARYLAND  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Bethesda** c. LENGTH OF STAY IN 1b **45 days**  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **The Clinical Center, Bethesda 14, Md.**

3. NAME OF DECEASED (Type or print) **Burnice Edward McKoy**

5. SEX **Male** 6. COLOR OR RACE **Negro** 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH **December 6, 1938** 9. AGE (In years last birthday) **22** yrs. IF UNDER 1 YEAR: Months **4** Days **19** Hours **61** Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Factory Worker** 10b. KIND OF BUSINESS OR INDUSTRY **Unknown** 11. BIRTHPLACE County & State, or foreign country: **North Carolina** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **Herman McKoy** 14. MOTHER'S MAIDEN NAME **Susan M. Morris**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **No** 16. SOCIAL SECURITY **Unascertainable** 17. INFORMANT **The Medical Record**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **Acute cardiac insufficiency**  
204.3 DUE TO  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) **Massive leukemic pericarditis**  
DUE TO (c) **Acute lymphocytic leukemia**  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e).  
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

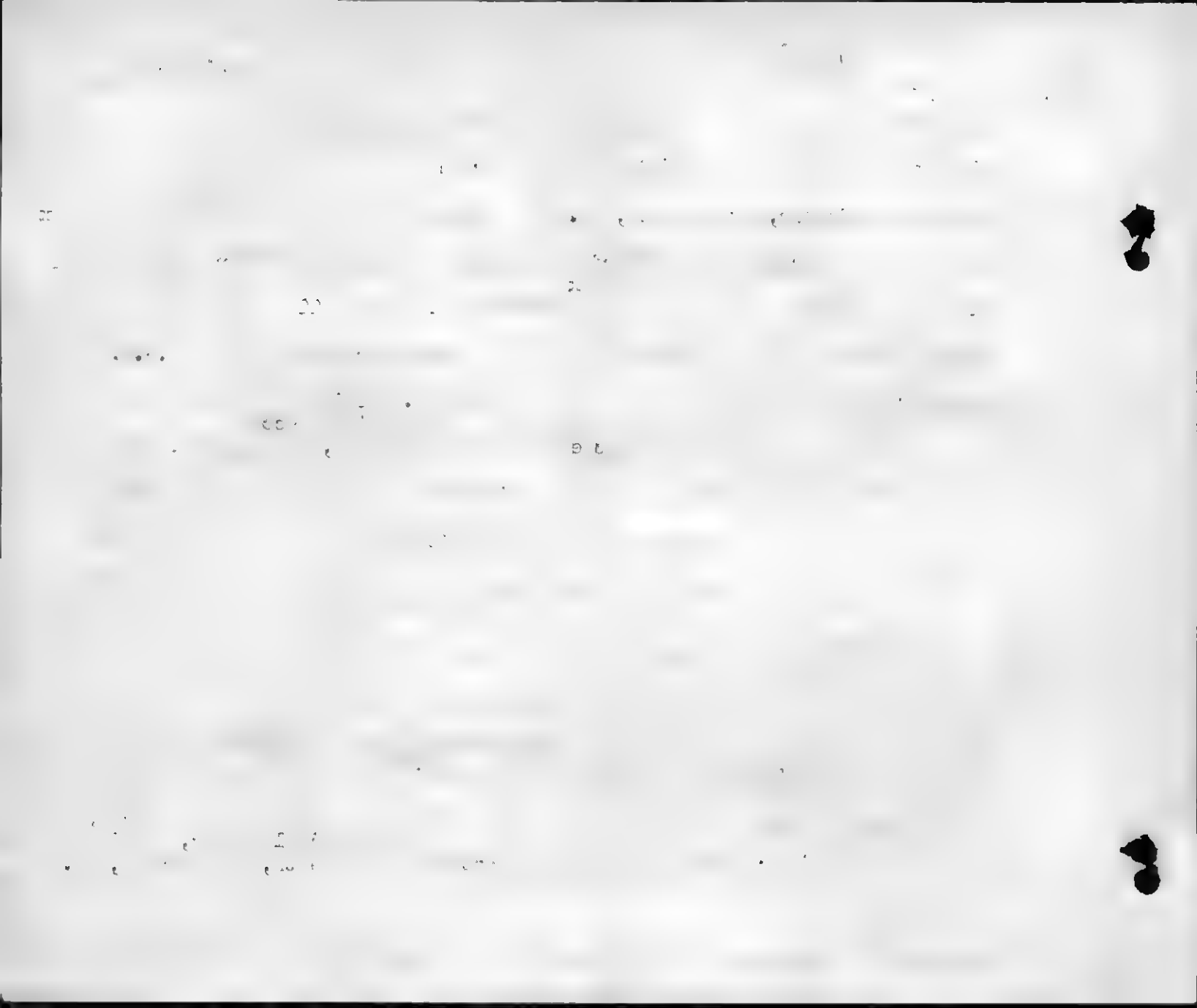
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  
20c. TIME OF INJURY Month, Day, Year **September 20, 1961** 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **The Clinical Center, National Institutes of Health, Bethesda 14, Md.** 20f. (City or town) **Bethesda** (County) **Montgomery** (State) **Md.**

21. I certify that (this hospital) attended the deceased from **September 20, 1961** to **November 4, 1961**, that (it) (we) last saw the deceased alive on **November 4, 1961**, and that death occurred at **12:50 PM**, from the causes and on the date stated above.

22a. SIGNATURE **Edward S. Henderson** M.D. 22b. DATE SIGNED **November 6, 1961**  
22c. PHYSICIAN'S NAME (Type) **Edward S. Henderson** 22d. ADDRESS **The Clinical Center, National Institutes of Health, Bethesda 14, Md.**

23a. BURIAL, CREMATION, REMOVAL (Specify) **11-7-61** 23b. DATE THEREOF **11-7-61** 23c. NAME OF CEMETERY OR CREMATORY **Sum North Carolina** 23d. LOCATION (City, town or county) **Sum North Carolina** (State) **North Carolina**

24. FUNERAL DIRECTOR'S SIGNATURE **Travis Turner** ADDRESS **389-R.D. Ave. N.W.** 25a. REC'D BY REGISTRAR **DATE NOV 8 '61** 25b. REGISTRAR'S SIGNATURE **Edward S. Henderson**

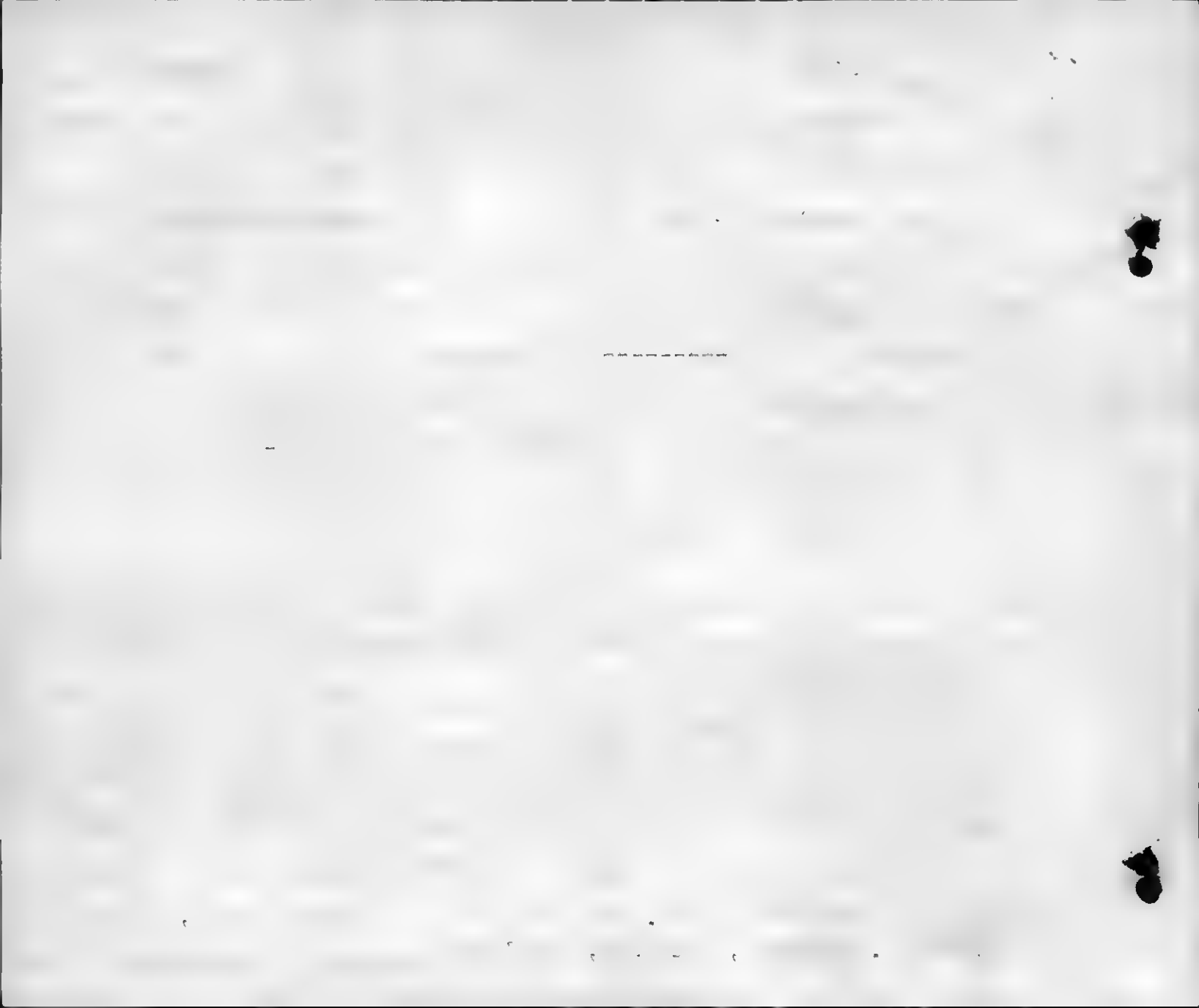


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
12858  
12844

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Crestview</u> c. LENGTH OF STAY IN b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4901 Crescent Street</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Crestview</u> d. STREET ADDRESS <u>4901 Crescent Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Annie Irene</u> 4. DATE OF DEATH <u>Nov. 21</u> 19 <u>61</u> 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>1/26/1879</u> 9. AGE (in years last birthday) <u>82</u> yrs. IF UNDER 1 YEAR Months <u>9</u> Days <u>25</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u> 11. BIRTHPLACE (Country & State, or foreign country) <u>Virginia</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Charles Croson</u> 14. MOTHER'S MAIDEN NAME <u>Eugene Lynn</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Edith Robey-daughter-same as above</u> Address <u></u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 170X DUE TO (b) <u>Carcinoma of Breast &amp; Generalized Metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) <u>Generalized Arteriosclerosis &amp; Hypertension</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1950</u> to <u>11/21</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>11/21</u> , 19 <u>61</u> , and that death occurred at <u>6 PM</u> , from the causes and on the date stated above. 22a. SIGNATURE <u>S A Thomas MD</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>11/21/61</u> 22c. PHYSICIAN'S NAME (Type) <u>S A Thomas MD</u> 22d. ADDRESS <u>4301 48th St NW WASH DC</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>11/25/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Nat. Memorial Park</u> 23d. LOCATION (City, town or county) (State) <u>Falls Church, Virginia</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u> ADDRESS <u></u> 25a. REC'D BY REGISTRAR <u>NOV 30 '61</u> 25b. REGISTRAR'S SIGNATURE <u></u>			



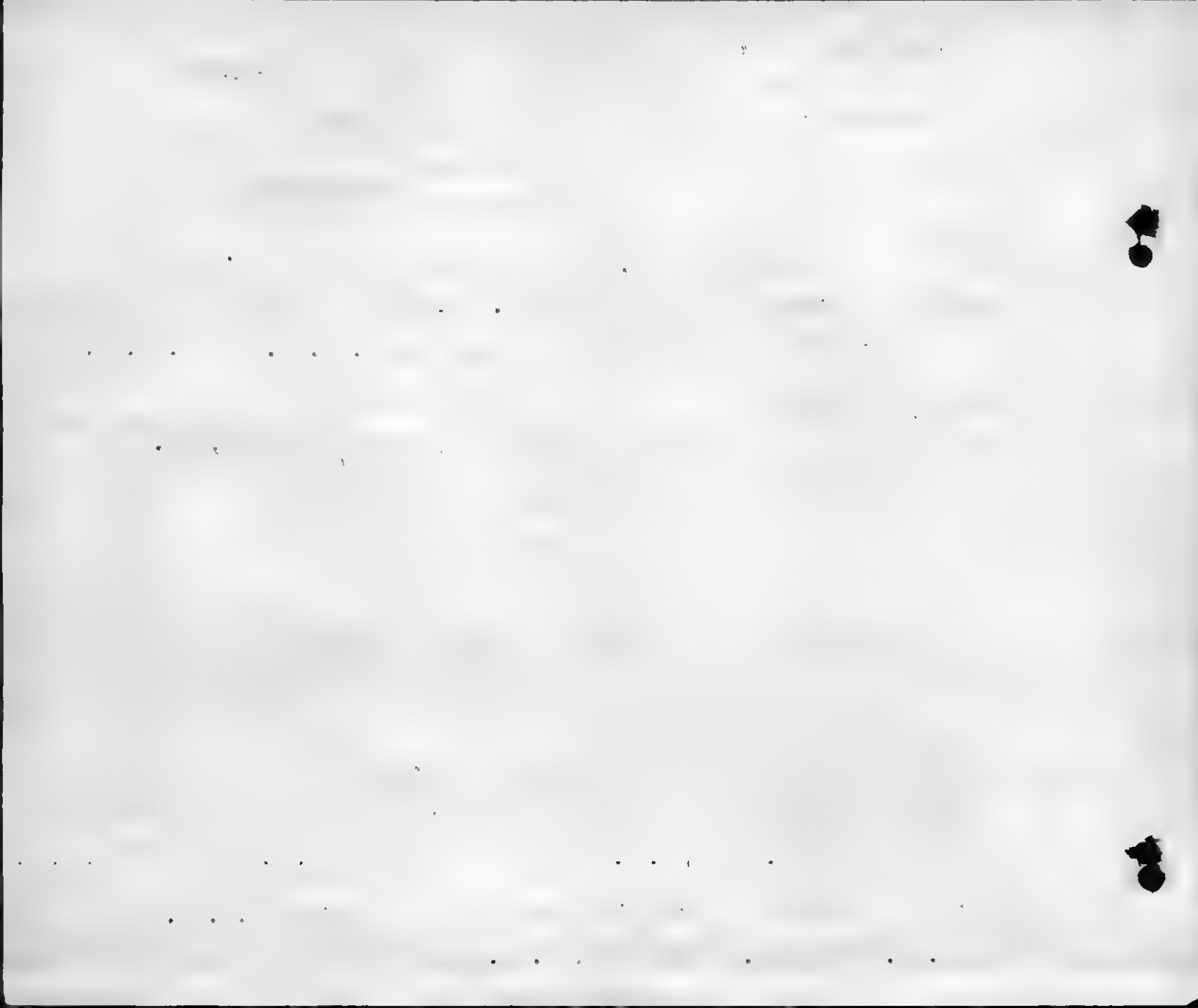
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN It d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Son's home</b>		2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. STREET ADDRESS (Springfield) <b>5515 Ridgefield Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Grace F. Meeks</b>		4. DATE OF DEATH <b>Nov. 30 1961</b>		5. AGE (In years last birthday) <b>86</b>	
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b>	
13. FATHER'S NAME <b>Joseph Fearson</b>		14. MOTHER'S MAIDEN NAME <b>Laura MacPherson</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Fearson S. Meeks</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO <b>arteriosclerosis Heart disease</b> DUE TO <b>arteriosclerosis Embolus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <b>Severe Mixed (Rheumatoid + osteo) arthritis</b>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>7/16</b> to <b>11/30</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>11/29</b> , 19 <b>61</b> , and that death occurred at <b>7:30 AM</b> , from the causes and on the date stated above.		22a. SIGNATURE <b>Marcel J. Foret</b> M.D. <b>11/30/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Marcel J. Foret, M. D.</b>		22d. ADDRESS <b>1746 K Street, N. W. Washington 6, D. C.</b>		22b. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/2/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>	
23d. LOCATION (City, town or county) <b>Washington, D. C.</b>		23e. REC'D BY REGISTRAR <b>DEC 1 '61</b>		23f. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Co. Washington, D. C.</b>		24b. ADDRESS		24c. DATE	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

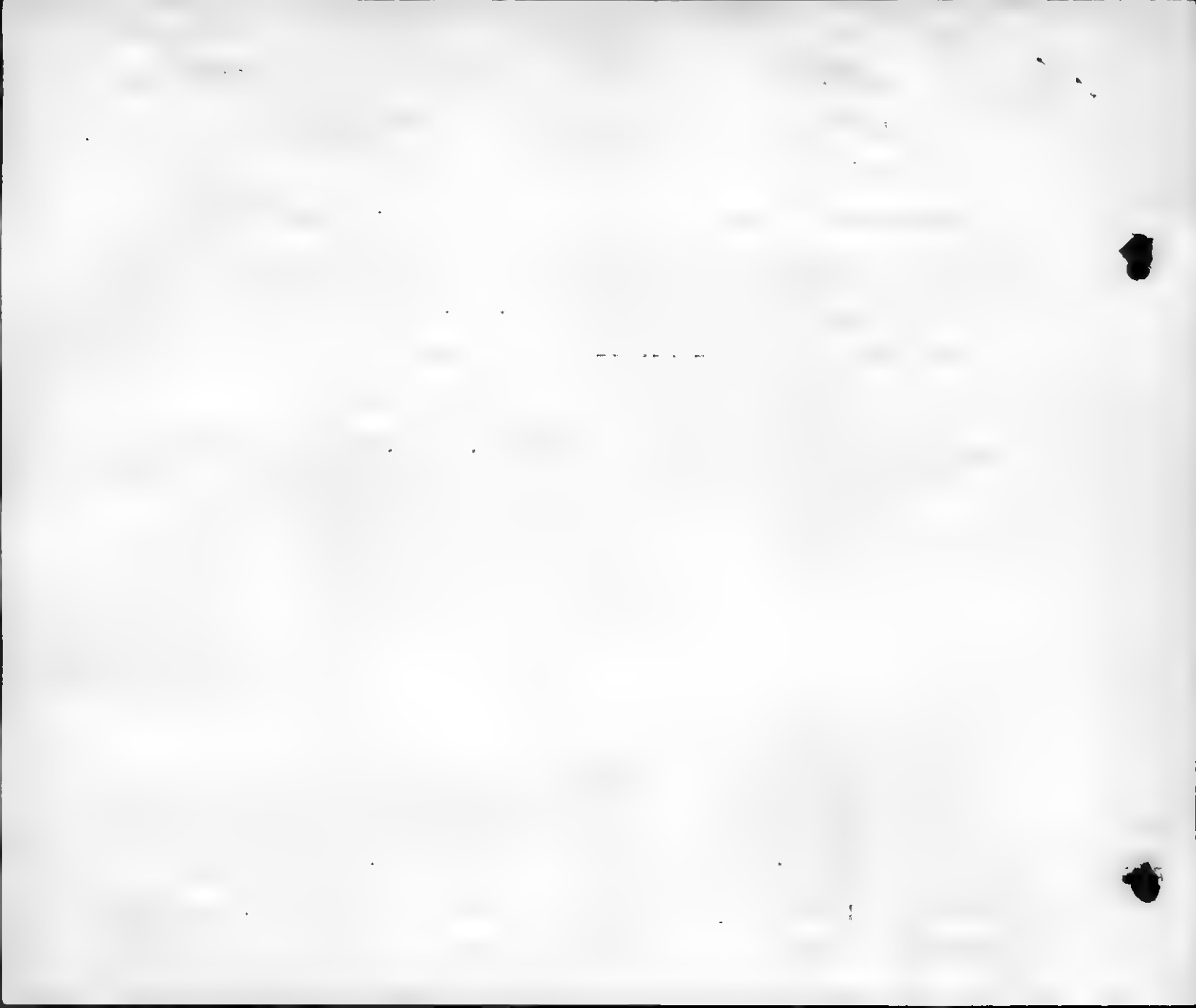
## CERTIFICATE OF DEATH

12860

12846

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7213 Beacon Terrace</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>7213 Beacon Terrace</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
<b>3. NAME OF DECEASED</b> (Type or print) <u>Louise Meyer</u>		<b>4. DATE OF DEATH</b> Month <u>November</u> Day <u>13</u> Year <u>1961</u>										
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Jan. 15, 1886</u>									
<b>9. AGE</b> (In years last birthday) <u>75</u> yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td></td> <td>Hours</td> </tr> <tr> <td></td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days		Hours		Min.	<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Georgia</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>USA</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		
IF UNDER 1 YEAR	IF UNDER 24 HRS.											
Months	Days											
	Hours											
	Min.											
<b>13. FATHER'S NAME</b> <u>Dietrich Plate</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Anna Lange</u>										
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> <u>Anna M. Woke, daughter-same 2d</u>										
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio-respiratory failure</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cerebral vascular accident</u> (c) <u>arteriosclerosis</u>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>2 hours</u> <u>5 days</u> <u>15 yrs.</u>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)										
<b>20c. TIME OF INJURY</b> Hour <u>19</u> a.m. <u>19</u> p.m.	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b>	<b>(County)</b>								
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Nov 13, 1961</u> <b>to</b> <u>13 Nov 1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>13 Nov 1961</u> , <b>and that death occurred at</b> <u>5:29 P</u> <b>from the causes and on the date stated above.</b>												
<b>22a. SIGNATURE</b> <u>John M. Wyman</u>		<b>22b. DATE SIGNED</b> <u>14 Nov 61</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>John M. Wyman</u>								
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>11/15/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Rockville Cemetery</u>								
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Bethesda, Robert A. Pumphrey, Maryland</u>		<b>25a. REC'D BY REGISTRAR</b> <u>NOV 16 '61</u>										
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kline</u>		<b>25c. LOCATION (City, town or county)</b> <u>Rockville, Maryland</u>										

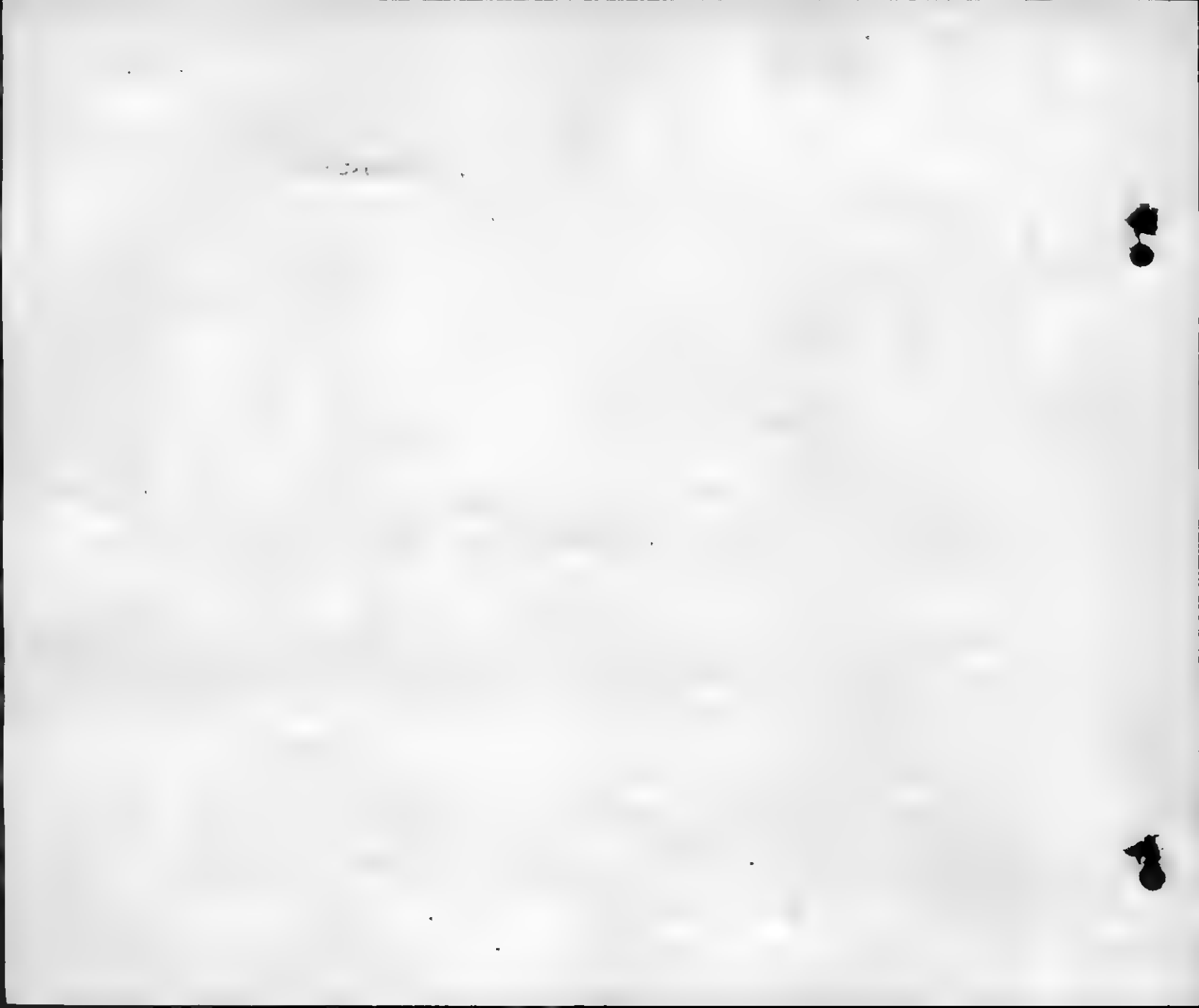
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



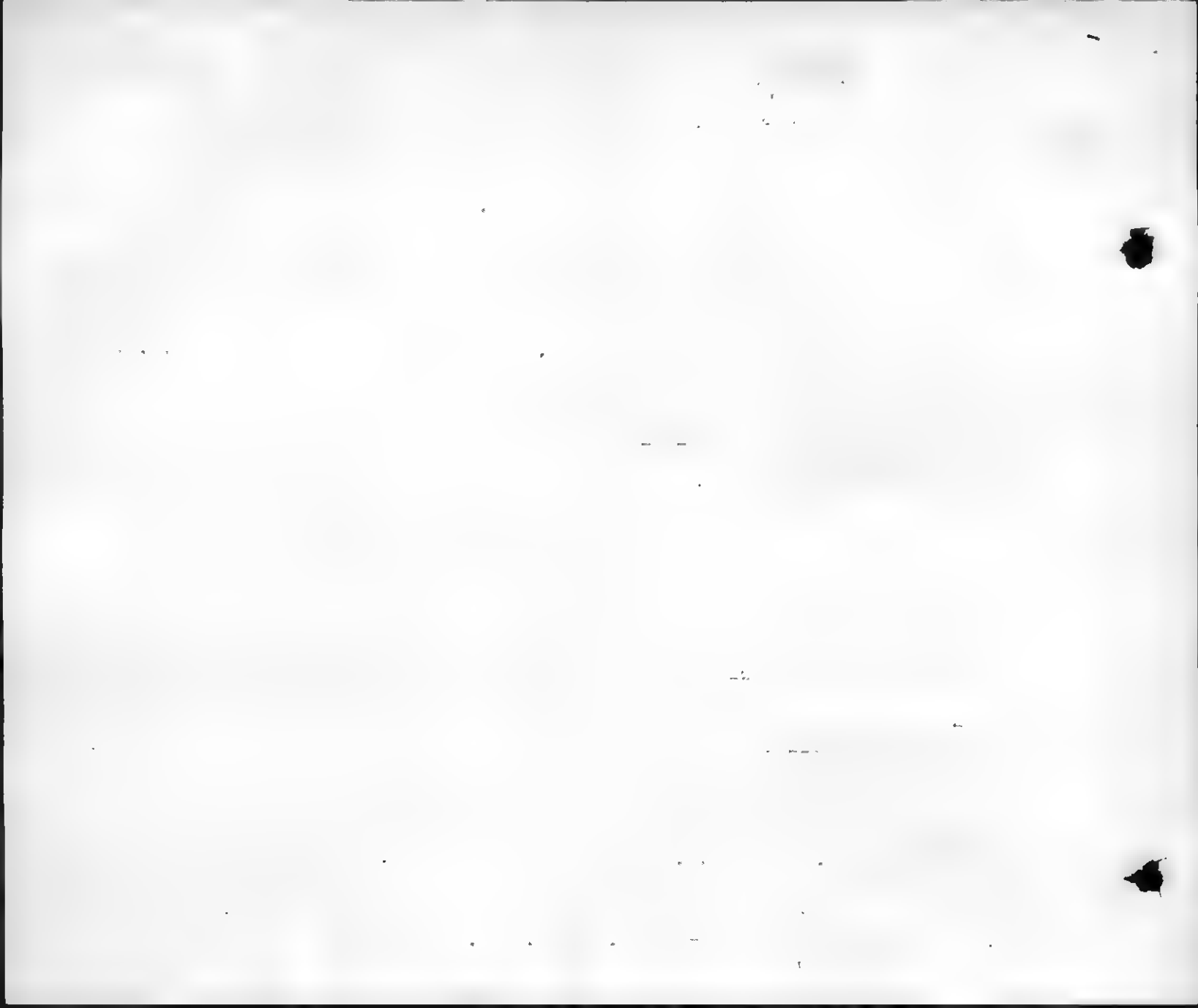
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the death occurs in a hospital, the certificate may be retained by the hospital or attending physician until the body is released. If the death occurs elsewhere, the certificate may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
12861 CERTIFICATE OF DEATH 12847

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>1 hr. 45 min.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Potomac</u> d. STREET ADDRESS <u>Meat Falls Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF (Type or print) <u>Samuel A. Miller</u>		4. DATE OF DEATH <u>Nov. 21 1961</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 28 1907</u>	
9. AGE (in years last birthday) <u>54 yrs.</u>		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Actuary</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Perman/VANIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Joseph Miller</u>	
14. MOTHER'S M maiden name <u>FANNIE ?</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes World War II</u>	
16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Lillian Miller (wife)</u> Address <u>(same as above)</u>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary occlusion</u> DUE TO <u>4-3-1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterio-sclerotic cardiovascular disease</u> DUE TO (c) <u>3 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>  </u> p.m. <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>August 1954</u> to <u>Nov. 21, 1961</u> , that (I) (we) last saw the deceased alive on <u>Nov. 21, 1961</u> , and that death occurred at <u>10:20 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Stephen C. Cromwell</u>		22b. DATE SIGNED <u>11/24/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>STEPHEN C. CROMWELL</u>		22d. ADDRESS <u>615 W. Montgomery Ave, Rockville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE HEREOF <u>11-24-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>NEW MONTEFIORE CEM.</u>		23d. LOCATION (City, town or county) (State) <u>NEW YORK</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>BERNARD DANZANSKY &amp; SONS</u>		25a. REC'D BY REGISTRAR <u>NOV 24 61</u>	
25b. REGISTRAR'S SIGNATURE <u>Paul S. Thomas</u>		25c. DATE	







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 7/61

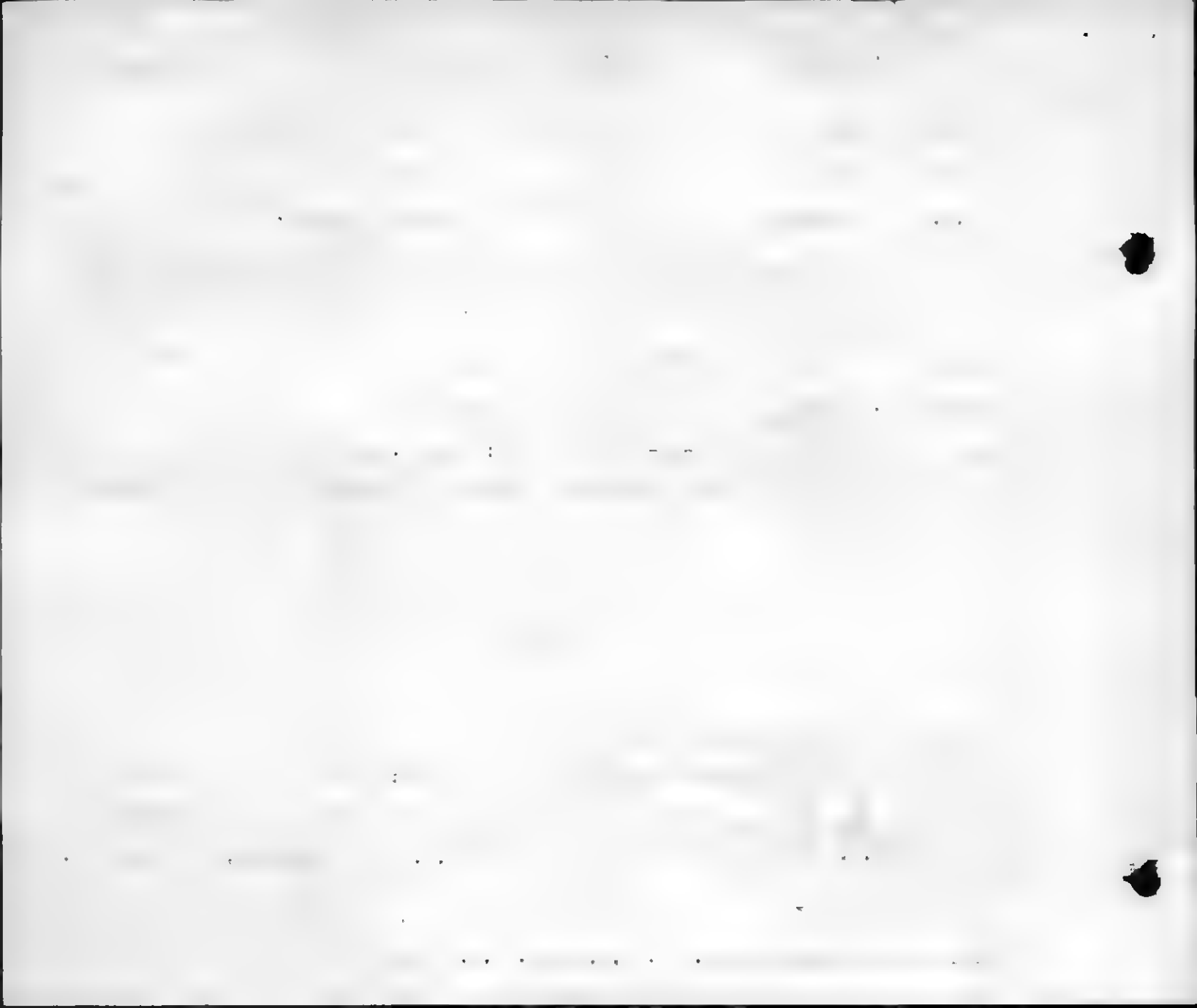
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12849

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maine</u> b. COUNTY <u></u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Thelma</u>	
c. LENGTH OF STAY in 1b <u>5 days</u>		d. STREET ADDRESS <u>17 Clifton Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U.S. Naval Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Roland</u> Middle <u>Banks</u> Last <u>Moore</u>		4. DATE OF DEATH Month <u>November</u> Day <u>10</u> Year <u>1961</u>	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>May 24, 1886</u>		9. AGE (In years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR Months <u></u> Days <u></u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Doctor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Medicine</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maine</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William S. Moore</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Toner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>WW I WW II</u> <u>005-42-8684</u>		16. SOCIAL SECURITY NO <u>005-42-8684</u>	
17. INFORMANT <u>WIFE: Anna A. Moore</u> Same as #2		Address <u></u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> 720.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>indet.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Uremia</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>6 November, 1961</u> to <u>10 November 1961</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>10 November 1961</u> , and that death occurred at <u>09:50 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>J. W. Brackett</u>		22b. DATE SIGNED <u>11-11-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. W. BRACKETT LT MC USN</u>		22d. ADDRESS <u>U.S. Naval Hospital, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>11-11-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Portland, Maine</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Rinaldi</u>		24b. ADDRESS <u>Rinaldi Funeral Home 816 H. St. N.E. Wash. D.C.</u>	
25a. REC'D BY REGISTRAR <u>NOV 15 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Ernest S. Thomas</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12864

CERTIFICATE OF DEATH

Reg. Dist. No. 12850

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Foots ville</u>		c. LENGTH OF STAY IN 1b <u>life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM</u> First <u>H.</u> Middle <u>MOORE</u> Last		4. DATE OF DEATH <u>November 24</u> Month <u>1961</u> Day <u>1961</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 3, 1875</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Moore</u>		14. MOTHER'S MAIDEN NAME <u>Annie Gault</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Informant</u> Address <u>Gertrude H. per. Foots ville Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> <u>acute congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cardiac hypertrophy</u> DUE TO (c) <u>Hypertensive Cardiovascular disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> <u>10 years</u> <u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis, marked.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While Not while of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan. 1950</u> to <u>Nov 24, 1961</u> , that I last saw the deceased alive on <u>Nov 22, 1961</u> , and that death occurred at <u>4:15 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John S. Lawrence</u> M.D.		DATE SIGNED <u>11/24/61</u>	
PHYSICIAN'S NAME (Type) <u>P.O. Boyd S. Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-28-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Jerusalem Baptist</u>	22d. LOCATION (City, town, or county) (State) <u>Foots ville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u> ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 1 '61</u>	24b. REGISTRAR'S SIGNATURE <u>John S. Howard</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

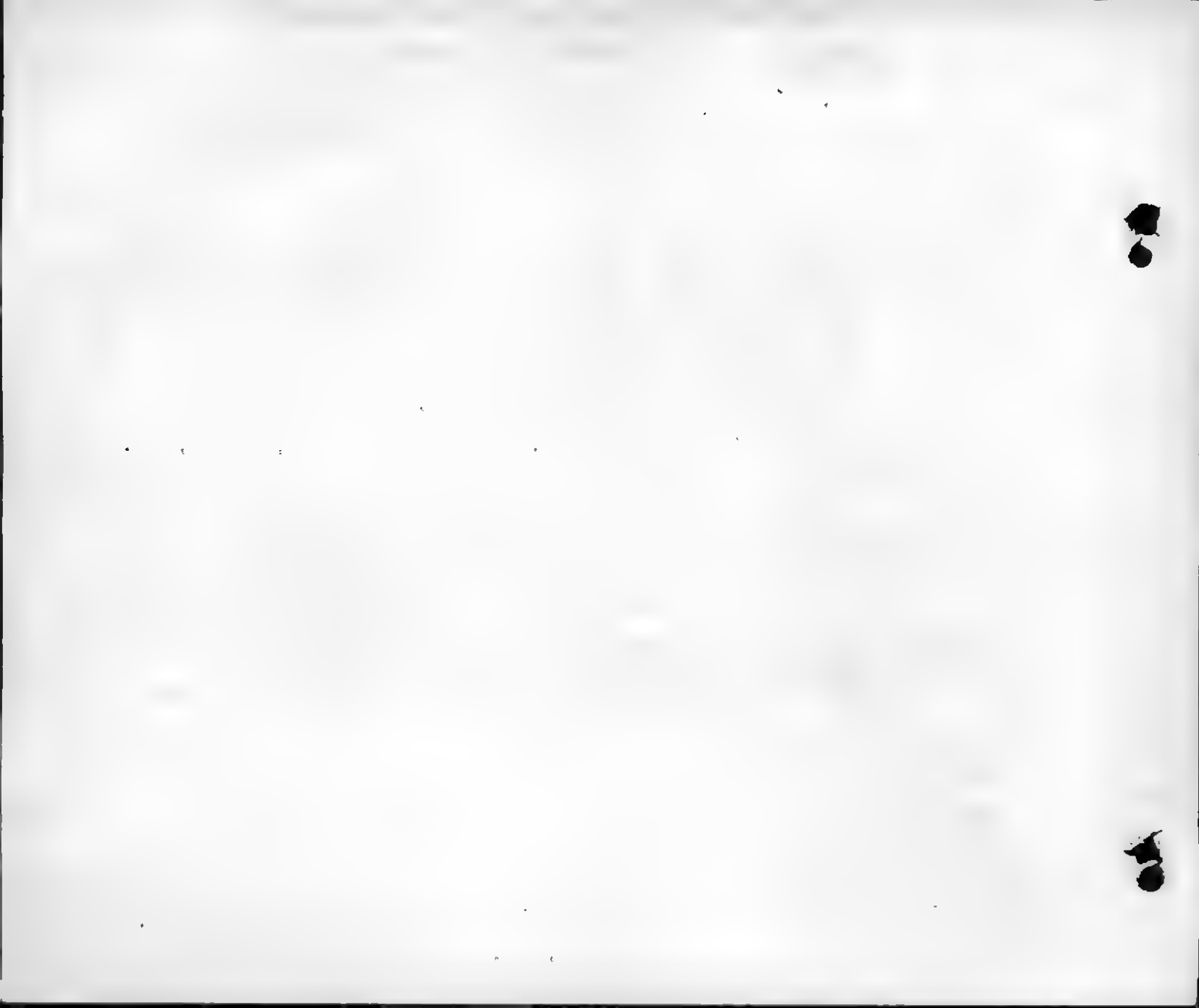
Reg. Dist. No.

12865

12851

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montg.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laytonsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brookgrove Foundation</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Calvin</u> Middle <u>W.</u> Last <u>Mullinix</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>14</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 19 1876</u>	
9. AGE (In years last birthday) <u>85</u> yrs		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grocer Store Manager</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Store</u>			
11. BIRTHPLACE (State or foreign country) <u>Montg. Co. Md</u>				12. CITIZEN OF WHAT COUNTRY? <u>American</u>			
13. FATHER'S NAME <u>James L. Mullinix</u>				14. MOTHER'S M maiden NAME <u>Mary Young</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>217-32-1144</u>			
17. INFORMANT <u>J. Carlton Mullinix, Olney, Md.</u>				Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Bronchopneumonia</u>							
(b) <u>Arteriosclerosis, generalized</u> DUE TO							
(c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>11/13/61</u> to <u>11/14/61</u> , that I last saw the deceased alive on <u>11/13/61</u> , and that death occurred at <u>7:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. H. L. [Signature]</u>				ADDRESS (Street, city or town, state) <u>Damascus, Md.</u> DATE SIGNED <u>11/14/61</u>			
PHYSICIAN'S NAME (Type) <u>C. H. L. [Signature]</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/17/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Laytonsville</u>		22d. LOCATION (City, town, or county) (State) <u>Laytonsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. L. [Signature]</u>				ADDRESS <u>Damascus, Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 17 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be added by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12866

12852

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. LENGTH OF STAY IN <u>21</u> days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NAS Patuxent River</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Naval Hospital</u>			d. STREET ADDRESS <u>710E MEM.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>3. NAME OF DECEASED</b> (Type or print) <u>Charles Edward Murphy Sr.</u>			<b>4. DATE OF DEATH</b> Last <u>November</u> 15, 19 <u>61</u>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 1, 1899</u>	9. AGE (In years last birthday) <u>62 yrs</u>	IF UNDER 1 YEAR Months <u>15</u> Days <u>15</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Barber</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>
13. FATHER'S NAME <u>Patrick Murphy</u>			14. MOTHER'S MAIDEN NAME <u>Sarah (Unknown)</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>167 03 0811</u>		
17. INFORMANT <u>SON Charles Edward Murphy Jr., Same as 2</u>			Address <u>Same as 2</u>		
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Carcinoma of Cecum, metastatic to liver</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) _____ PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.) _____ 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____					
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>October 25, 1961</u> to <u>November 14, 1961</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>November 14, 1961</u> , and that death occurred at <u>12:20 PM</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>John W. Brackett, Jr.</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED <u>November 14, 1961</u>					
22c. PHYSICIAN'S NAME (Type) <u>JOHN W. BRACKETT JR. LT MC USN</u> <u>U. S. Naval Hospital, Bethesda, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>11-15-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Plum Creek Cemetery, New Texas, Pennsylvania</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey</u> ADDRESS <u>3434 Georgia Ave., Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 17 '61</u>		25b. REGISTRAR'S SIGNATURE <u>C. H. House</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

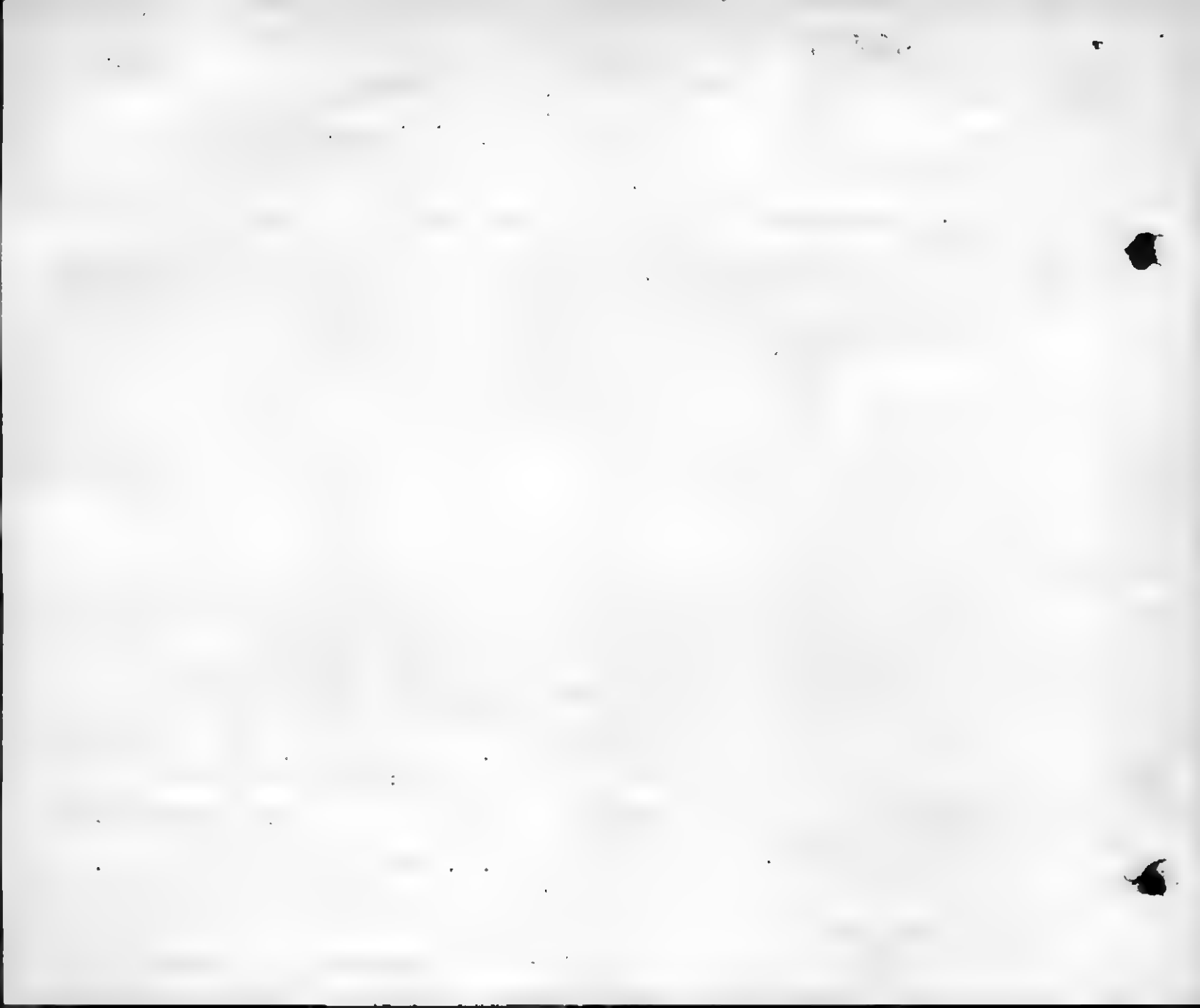
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 23b, Film G301 11/30/61 1wk

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN lb <u>78 days</u>		d. STREET ADDRESS <u>2101 Connecticut Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Naval Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William John Murphy</u>		4. DATE OF DEATH Month <u>November</u> Day <u>23</u> Year <u>1961</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <u>DIVORCED</u>		8. DATE OF BIRTH <u>Aug. 29, 1897</u>	
9. AGE (In years last birthday) <u>64 yrs.</u>		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Naval Officer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Thomas Murphy</u>		14. MOTHER'S MAIDEN NAME <u>Nora Graney</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WWII</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>  </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Bladder</u> <u>181.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e): <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that <u>  </u> (this hospital) attended the deceased from <u>Sept. 7, 1961</u> to <u>Nov. 23, 1961</u> , that <u>  </u> (we) last saw the deceased alive on <u>Nov. 23, 1961</u> , and that death occurred at <u>11:45 PM</u> the causes and on the date stated above.			
22a. SIGNATURE <u>William C. Monell</u> M.D.		22b. DATE SIGNED <u>November 24, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM C. MONELL, LT MC USN</u>		22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/28/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Gawlers Inc.</u>		25a. REC'D BY REGISTRAR <u>  </u>	
25b. REGISTRAR'S SIGNATURE <u>  </u>		DATE <u>NOV 27 '61</u>	



12868

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

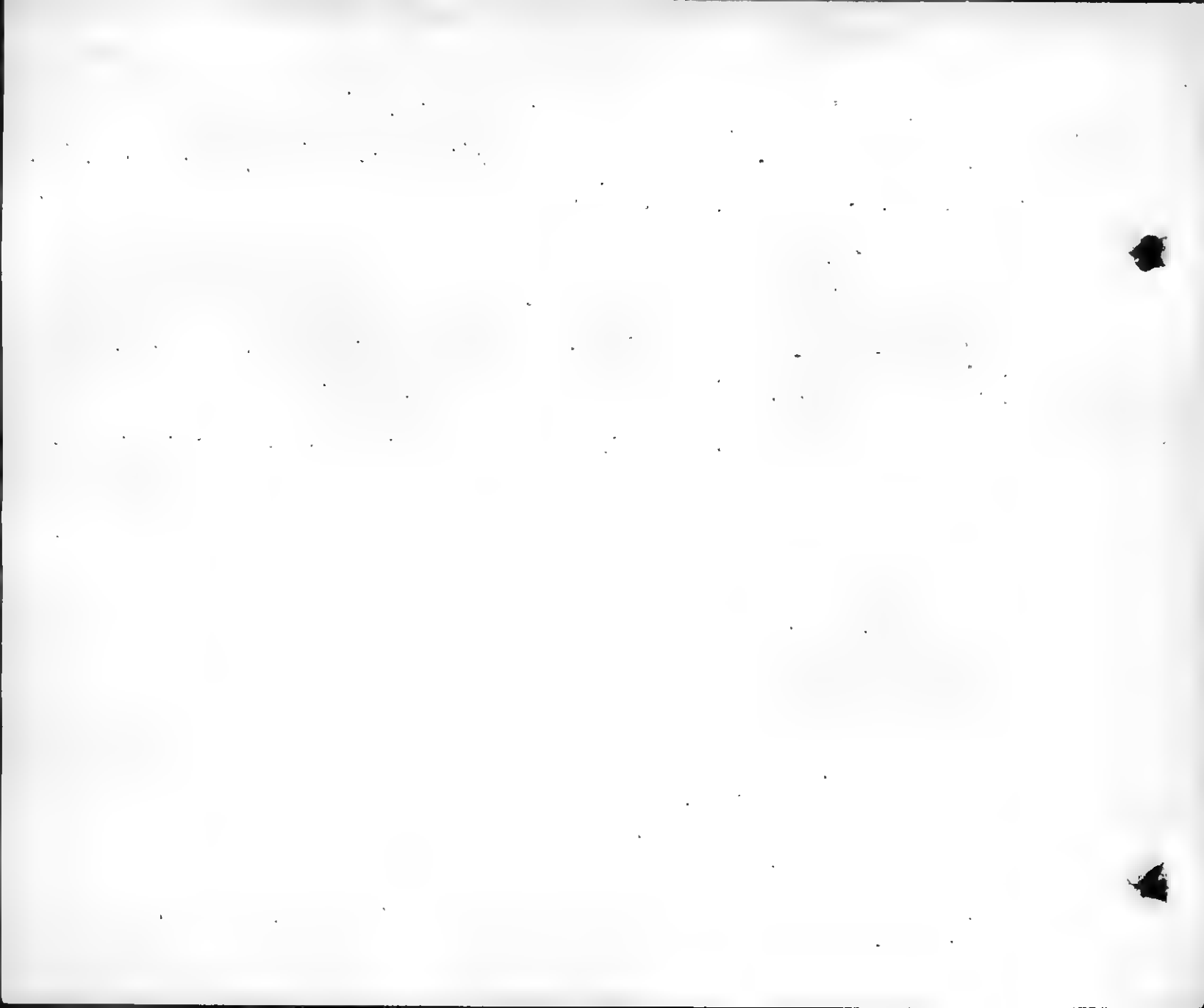
Reg. Dist. No. 12854

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>6611-23rd Place, N. Hyattsville</u>	
c. LENGTH OF STAY IN 1b <u>11/3/61</u>		d. STREET ADDRESS <u>md. 1652</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Althea Woodland Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Daisy</u> Middle <u>G.</u> Last <u>Myers</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>6th</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 22, 1881</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR: Months <u>7</u> Days <u>1</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>London County, Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James B. Furtney</u>		14. MOTHER'S MAIDEN NAME <u>Susan Virts</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-09-34720</u>	
17. INFORMANT <u>Susan M. Maher, Daughter</u>		Address <u>above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Phlebotrombosis</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 1 days</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus - Acute</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1948</u> , to <u>Nov 6, 1961</u> , that I last saw the deceased alive on <u>Nov 6, 1961</u> , and that death occurred at <u>1 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert B. Lee</u>		ADDRESS (Street, city or town, state) <u>705 Ridge Rd. Hyattsville, Md.</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT B LEE</u>		DATE SIGNED <u>Nov 6, 1961</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/9/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Halley's Funeral Home, Inc.</u>		24a. REC'D BY REGISTRAR <u>NOV 10 '61</u>	
ADDRESS <u>4th Rainier Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

2

1

10/10



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12869

12855

1. PLACE OF DEATH  
a. COUNTY Montgomery County  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington  
c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)  
Carroll Hall Sanitarium

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)  
a. STATE D. C. b. COUNTY Washington  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington

d. STREET ADDRESS 5031 -5th Street N. W.  
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

First Middle Last  
ESTELLE VERNAY MYERS

4. DATE OF DEATH  
Month Day Year  
Nov. 1 1961

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

Nov 14th 1874

9. AGE (Years last day)

86 yrs.

IF UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or for country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Vernay

14. MOTHER'S MAIDEN NAME

Elizabeth Wright

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give service record)

no

16. SOCIAL SECURITY NO. 17. INFORMANT

none

Address Kensington, Md.

Hospital Records-10231 Carroll Pl.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

331X DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

CEREBRAL HEMORRHAGE

ESSENTIAL HYPERTENSION

GENERALIZED ARTERIOSCLEROSIS

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)

SENILITY

INTERVAL BETWEEN ONSET AND DEATH

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from MAY 15, 1960 to Nov. 1st, 1961, that (I) (we) last saw the deceased alive on Nov. 1st, 1961, and that death occurred at 5:00 PM, from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

Henry M. Lowden

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS. ☐

22d. ADDRESS

3806 NORWAY DR. CHEVY CHASE, MD.

22b. DATE SIGNED  
NOV. 1-1961

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

11/4/61

23c. NAME OF CEMETERY OR CREMATORY

Mt. Olivet Cemetery

23d. LOCATION (City, town or county)

Fredrick, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE

The D. H. Jones Co., 2901 14th St NW

ADDRESS

25a. REC'D BY REGISTRAR

NOV 3 1961

25b. REGISTRAR'S SIGNATURE

Arthur S. Thomas

TO POSTMASTER: OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

11



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

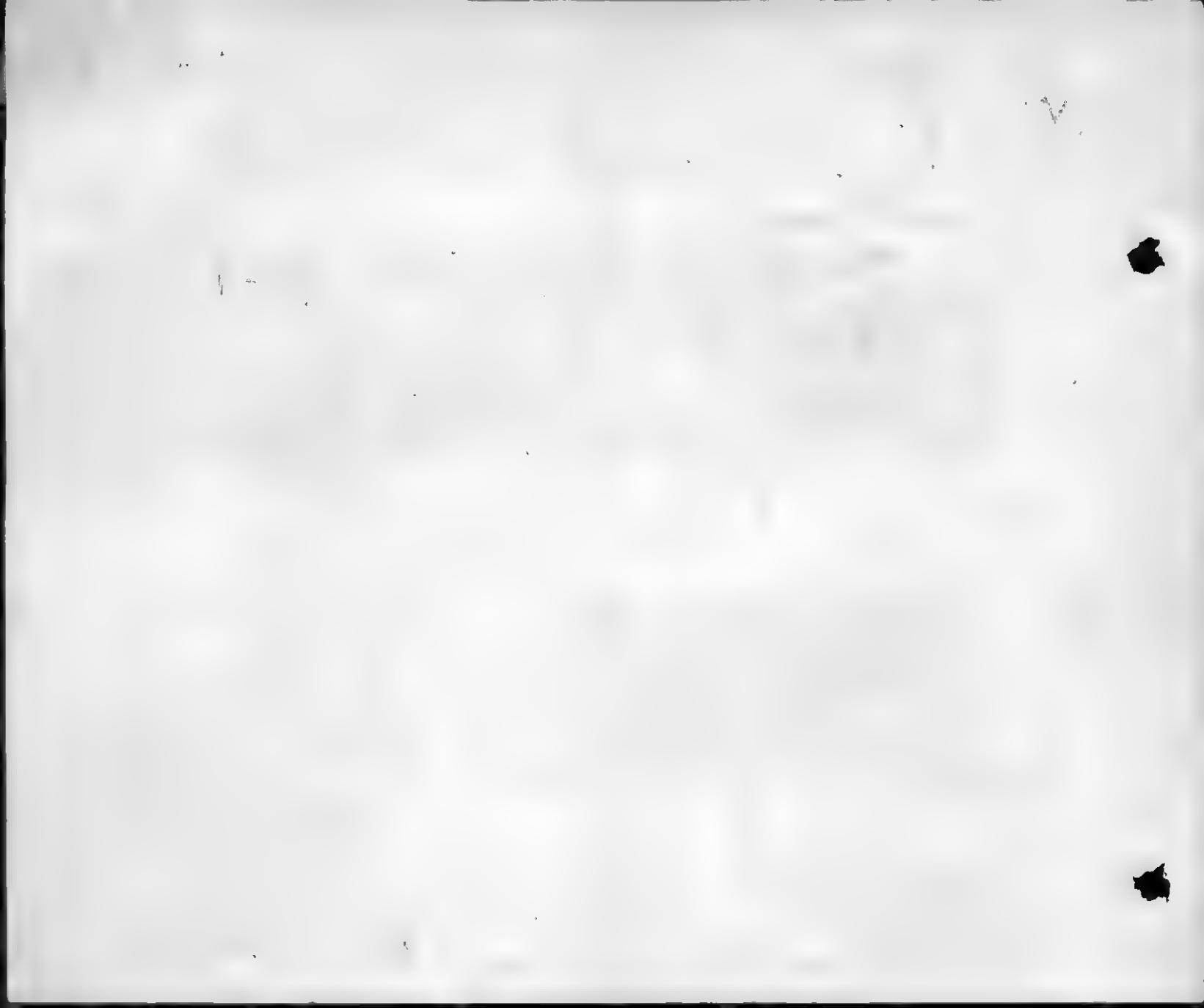
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

128570

12856

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - SILVER SPRING, MD.</u> c. LENGTH OF STAY IN IL <u>8 wks</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>LE DEAU-GARDENS</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTG.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER-SPRING, MD.</u> d. STREET ADDRESS <u></u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>BLANCHE - PARKER - NELSON</u> First Middle Last		<b>4. DATE OF DEATH</b> Month <u>Nov</u> Day <u>1</u> Year <u>1961</u>		<b>9. AGE</b> (In years last birthday) <u>63</u> yrs IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
<b>5. SEX</b> <u>F</u> <b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Feb. 19 - 1898</u>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Sock - Clerk</u>	
<b>11. BIRTH PLACE</b> (County & State or foreign country) <u>U.S. Good R. Wash. D.C.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A</u>		<b>13. FATHER'S NAME</b> <u>Mrs. J. Parker</u>	
<b>14. MOTHER'S MAIDEN NAME</b> <u>Blanche Kenney</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>7313</u>	
<b>17. INFORMANT</b> <u>Wm. P. Long</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertension, Etiology Unknown</u> DUE TO (b) <u>Repeated Cerebral Thromboses.</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18) <u></u>	
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a.m. <u></u> p.m. <u></u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Syp</u>	
<b>20f. (City or town)</b> <u>Syp</u>		<b>20g. (County)</b> <u>Montg.</u>		<b>20h. (State)</b> <u>MD</u>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Syp</u> <b>19</b> <u>Oct 31</u> <b>19</b> <u>61</u> <b>to</b> <u>Oct 31</u> <b>19</b> <u>61</u> <b>that (I) (we) last saw the deceased alive on</b> <u>Oct 31</u> <b>19</b> <u>61</u> <b>and that death occurred at</b> <u>2 P.M.</u> <b>from the causes and on the date stated above.</b>		<b>22a. SIGNATURE</b> <u>Robert T. Thibadeau</u> M.D.		<b>22b. DATE SIGNED</b> <u>Nov 1 - 61</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>ROBERT T. THIBADEAU</u>		<b>22d. ADDRESS</b> <u>10601 CONCORD ST. KENS., MD.</u>		<b>22e. RECORD BY REGISTRAR</b> <u>NOV 6 '61</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>Nov 4 - 1961</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Nick Creek Cemetery</u>	
<b>23d. LOCATION</b> (City, town or county) <u>Jacksonville</u>		<b>23e. (State)</b> <u>FLA.</u>		<b>25a. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Hume</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J. Arthur Walter</u>		<b>24b. ADDRESS</b> <u>254 Carroll St. NW D.C.</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Hume</u>	



VS. A15M  
5M 9/60



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12858

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>2 hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sun &amp; Hoops</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> d. STREET ADDRESS <u>3423 Nimitz Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Leigh Lanman Nettleton</u> First Middle Last		<b>4. DATE OF DEATH</b> <u>Nov 13 1961</u> Day Month Year	
<b>5. SEX</b> <u>male</u>	<b>6. COLOR OF RACE</b> <u>white</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>11-14-46</u>	<b>9. AGE</b> (In years last birthday) <u>14</u> yrs. IF UNDER 1 YEAR: Months <u>11</u> Days <u>13</u> Hours <u>13</u> Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>School boy</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>etc.</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>etc.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Leigh L. Nettleton, Jr.</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Dollie C Nettleton</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>	
<b>17. INFORMANT</b> <u>Parents</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive inter thoracic hemorrhage</u> DUE TO (b) <u>Complete separation 11+12 dorsal vertebrae</u> DUE TO (c) <u>Struck by auto</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <u>LACERATION OF LIVER AND FRACTURE LEFT FEMUR.</u>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b> <u>Pedestrian struck by auto</u>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Struck by auto</u>	
<b>20c. TIME OF INJURY</b> Hour <u>4:40 p.m.</u> Month <u>11</u> Day <u>13</u> Year <u>1961</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>street</u>	<b>20f. (City or town)</b> <u>Washington</u>
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>	
<b>SIGNATURE</b> <u>Frank J. Broschart</u>		<b>DATE SIGNED</b> <u>11-14-61</u>	
<b>EXAMINER'S NAME</b> (Type) <u>FRANK J. Broschart</u>		Address (Street, city, town, or county) <u>Washington D.C.</u>	
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>11/17/61</u>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Glenwood Cemetery</u>		<b>22d. LOCATION</b> (City, town, or country) (State) <u>Washington D.C.</u>	
<b>23. FUNERAL DIRECTOR</b> <u>Warner E. Pimphrey, Inc.</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Charles L. Kraus</u>	
<b>24a. REC'D BY REGISTRAR</b> <u>NOV 16 '61</u>		Address (Street, city, town, or county) <u>4534 GEORGIA AVENUE SILVER SPRING, MARYLAND</u>	

TO LOCALITY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Delay is necessary. Please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>8 hrs</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. NAVAL HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Washington, D.C.</b> b. COUNTY <b>✓</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>418 2</b> d. STREET ADDRESS <b>1901 23rd Street, S.E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Twin-A Baby Girl Nicles</b>		4. DATE OF DEATH Month <b>November</b> Day <b>11</b> Year <b>1961</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 11, 1961</b>	
9. AGE (In years last birthday) <b>8 yr 7 mo 10</b>		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>7</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (Country & State, or foreign country) <b>Montgomery, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Clayton E. Nicles</b>		14. MOTHER'S MAIDEN NAME <b>Patricia Mae Rinehart</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>Clayton E. Nicles</b>		Address <b>1901 23rd St., S.E. Wash. D.C.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Immaturity (1 lb. 3 oz)</b> DUE TO <b>776X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>776X</b> DUE TO (c) <b>776X</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>7 hrs 40 min</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>10</b> (this hospital) attended the deceased from <b>11 November, 1961</b> , to <b>11 November 1961</b> that <b>11</b> (we) last saw the deceased alive on <b>11 November 1961</b> , and that death occurred at <b>06:25 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>M.C. OBANNON JR.</b>		22b. DATE SIGNED <b>11-11-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>M.C. OBANNON JR. LT MC USN</b>		22d. ADDRESS <b>U.S. NAVAL HOSPITAL, BETHESDA, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-14-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Forest Oak Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Gaithersburg, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler</b>		25a. REC'D BY REGISTRAR <b>NOV 14 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		25c. ADDRESS <b>1331 E. Montgomery Ave. Rockville, Maryland</b>	

151 22-40

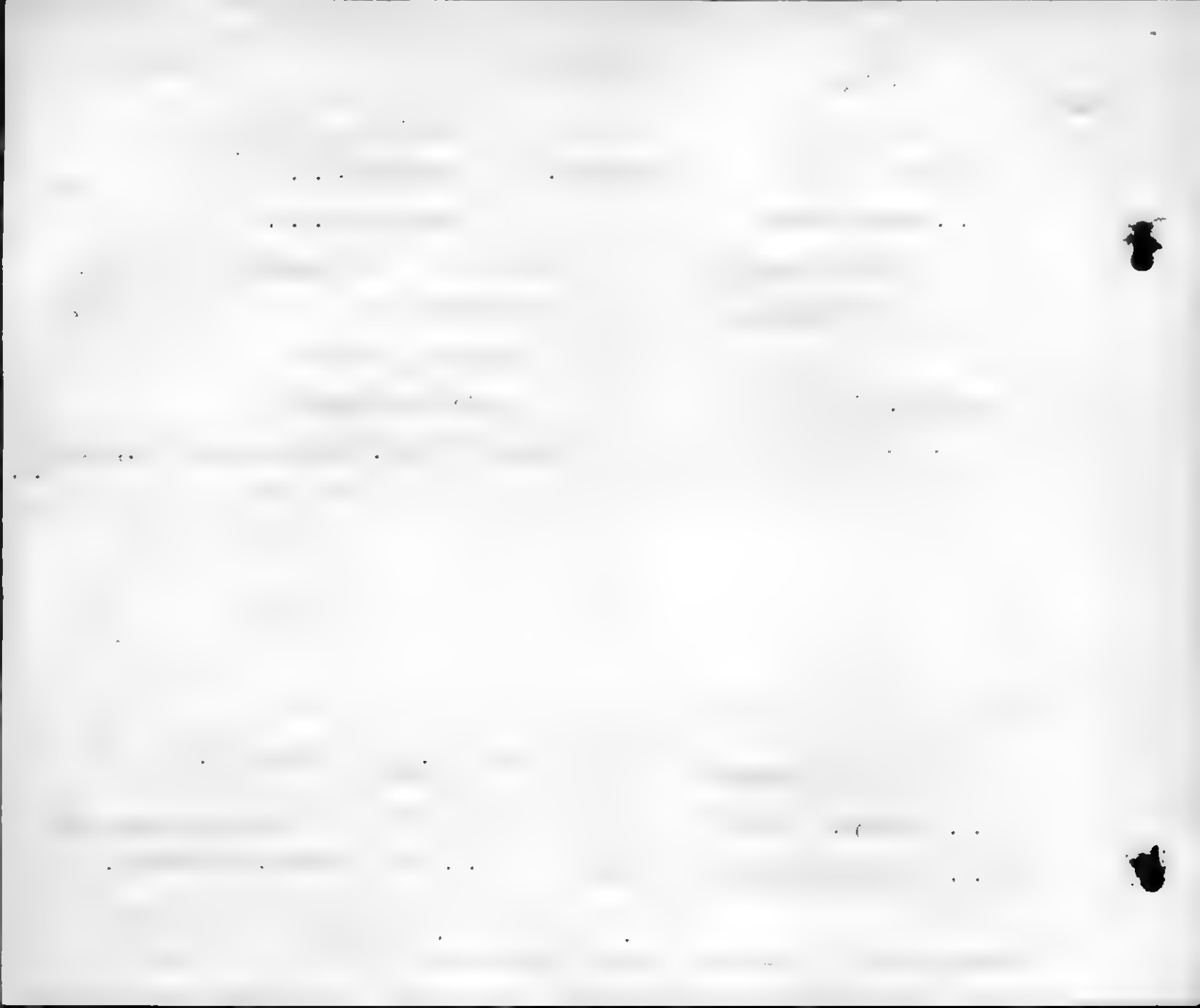


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN TB <b>8 hrs 40min.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. NAVAL HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland-D.C.</b> b. COUNTY <b>Washington, D.C.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b> d. STREET ADDRESS <b>1901 23rd ST.S.E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>TWIN"B" BABY GIRL</b>		4. DATE OF DEATH <b>NOVEMBER 11 1961</b>	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>CAUCASIAN</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>11 NOVEMBER 1961</b>	
9. AGE (In years last birthday) <b>8</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>20</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Montgomery, Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>Clayton E. Nicles</b>		14. MOTHER'S MAIDEN NAME <b>Patricia Mae Rinehart</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>FATHER: Clayton E. Nicles, 1901 23rd ST., SE, WASH, D.C.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Immaturity (1 lb 5 oz)</b> Conditions, if any, which gave rise to immediate cause (b) <b>776X</b> (c) <b>8 hrs 20 min</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>1901 23rd ST., SE, WASH, D.C.</b>		(Country) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>1050, 11 NOV. 1961</b> , to <b>1910, 11 NOV 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>11 November 1961</b> , and that death occurred at <b>1910</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>M.C. O'BANNON, LT MC USN</b>		22b. DATE SIGNED <b>11 November 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>M.C. O'BANNON, LT MC USN</b>		22d. ADDRESS <b>U.S. NAVAL HOSPITAL, BETHESDA, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-14-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Forest Oak Cemetery</b>		23d. LOCATION (City, town or county) <b>Gaithersburg, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler</b>		25. REC'D BY REGISTRAR <b>NOV 14 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			



TO VITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO VITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 20-1-61 ans 301

11-1-61 ans  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12875

12861

1. PLACE OF DEATH  
a. COUNTY Montgomery  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park  
c. LENGTH OF STAY IN MARYLAND 8 hrs.  
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASH. SAN. & Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)  
a. STATE District of Columbia  
b. COUNTY Washington  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington  
d. STREET ADDRESS 3724-17th St. N.E.

3. NAME OF DECEASED (Type or print) Ethel First NMN Middle O'CONNOR Last  
4. DATE OF DEATH Nov. 9 1961  
5. SEX FC 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH 9/12/1879  
9. AGE (In years last birthday) 79 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.  
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY None 11. BIRTHPLACE (County & State, or foreign country) England 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Ned Shaw 14. MOTHER'S MAIDEN NAME Mary ANN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. PT'S CHART 17. INFORMANT PT'S CHART Address PT'S CHART

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Coronary Thrombosis  
830X DUE TO  
Conditions, if any, which gave rise to immediate cause (b) Multiple Fracture Pelvis  
(a), stating the underlying cause last. DUE TO (c) 10 hrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Bumper of daughter's car struck her hip; car in garage

20c. TIME OF INJURY Month, Day, Year Hour a.m. 4:00 AM 1961 p.m. 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☒ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) Washington DC. (County) DC (State) DC

21. I certify that (I) (this hospital) attended the deceased from Jan 2 1957 to Nov 9 1961, that (I) (we) last saw the deceased alive on Nov 9 1961, and that death occurred at 4:00 PM from the causes and on the date stated above

22a. SIGNATURE W.B. Wardrop M.D. 22b. DATE SIGNED Nov 9 1961

22c. PHYSICIAN'S NAME (Type) W.B. WARDROP M.D. 22d. ADDRESS 800 Pershing Drive, Washington D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 11-13-61 23c. NAME OF CEMETERY OR CREMATORY St. Lincolns Cemetery 23d. LOCATION (City, town, or county) Prince Georges County Md. (State) Md.

24. FUNERAL DIRECTOR'S SIGNATURE Francis A. Collins BY MR ADDRESS 3821 14th St WASHINGTON 25a. REC'D BY REGISTRAR NOV 13 '61 25b. REGISTRAR'S SIGNATURE Arthur J. Hanna

1.7



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

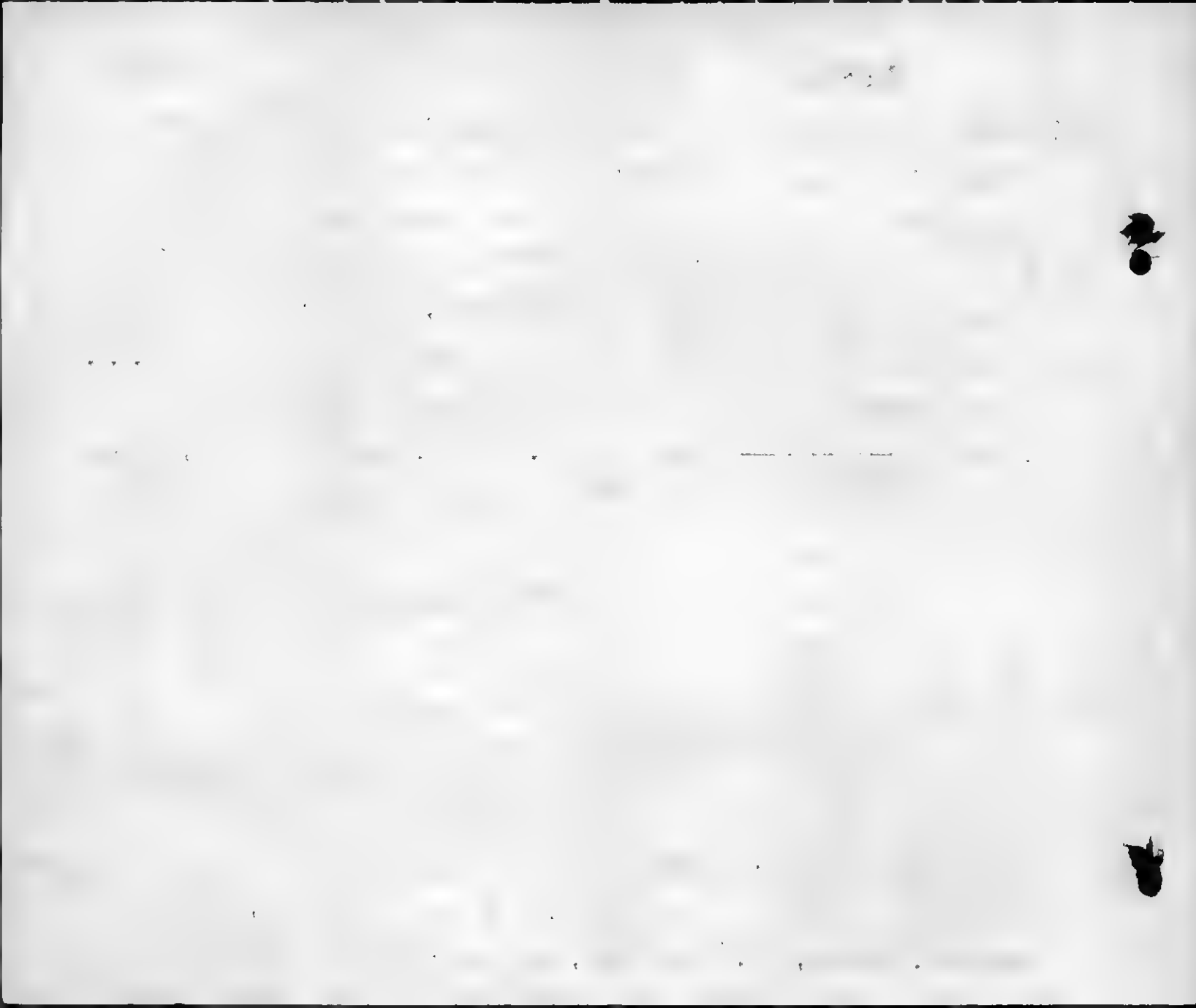
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12876

12862

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. LENGTH OF STAY IN b <b>3 years</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		d. STREET ADDRESS <b>2702 Harmon Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>MARY AGNES PARDUHN</b>		First		Middle		Last		4. DATE OF DEATH <b>November 26 1961</b>		Month		Day		Year			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 23, 1877</b>		9. AGE (In years last birthday) <b>84 yrs.</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Michael Stupp</b>		14. MOTHER'S MAIDEN NAME <b>May Buckley</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Hyland A. Bizot</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCT</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CORONARY OCCLUSION</b> (c) <b>ARTERIO SCLEROSIS</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>chronic debilitation</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>		YEARS									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Silver Spring</b>		(County) <b>Montgomery</b>		(State) <b>Md.</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>May 1958</b> to <b>2-22-61</b> , that (I) (we) last saw the deceased alive on <b>2-12-61</b> , and that death occurred at <b>8:30 A.M.</b> from the causes and on the date stated above.		22a. SIGNATURE <b>Richard P. Delaney</b>		22b. DATE SIGNED <b>2-22-61</b>		22c. PHYSICIAN'S NAME (Type) <b>RICHARD P. DELANEY</b>		22d. ADDRESS <b>4323 Harvard St Silver Spring, Md.</b>		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. DATE SIGNED <b>2-22-61</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11/28/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL CEMETERY</b>		23d. LOCATION (City, town or county) <b>ARLINGTON, VIRGINIA</b>		23e. REC'D BY REGISTRAR <b>NOV 28 '61</b>		23f. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Pumphrey</b>		24a. ADDRESS <b>8434 GEORGIA AVENUE</b>		24b. CITY, TOWN OR COUNTY <b>SILVER SPRING, MARYLAND</b>		24c. STATE <b>MARYLAND</b>		24d. ZIP CODE <b>20910</b>		24e. PHONE NO. <b>444-1111</b>		24f. FAX NO. <b>444-1111</b>		24g. E-MAIL <b>warner@pumphrey.com</b>		24h. WEBSITE <b>www.pumphrey.com</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

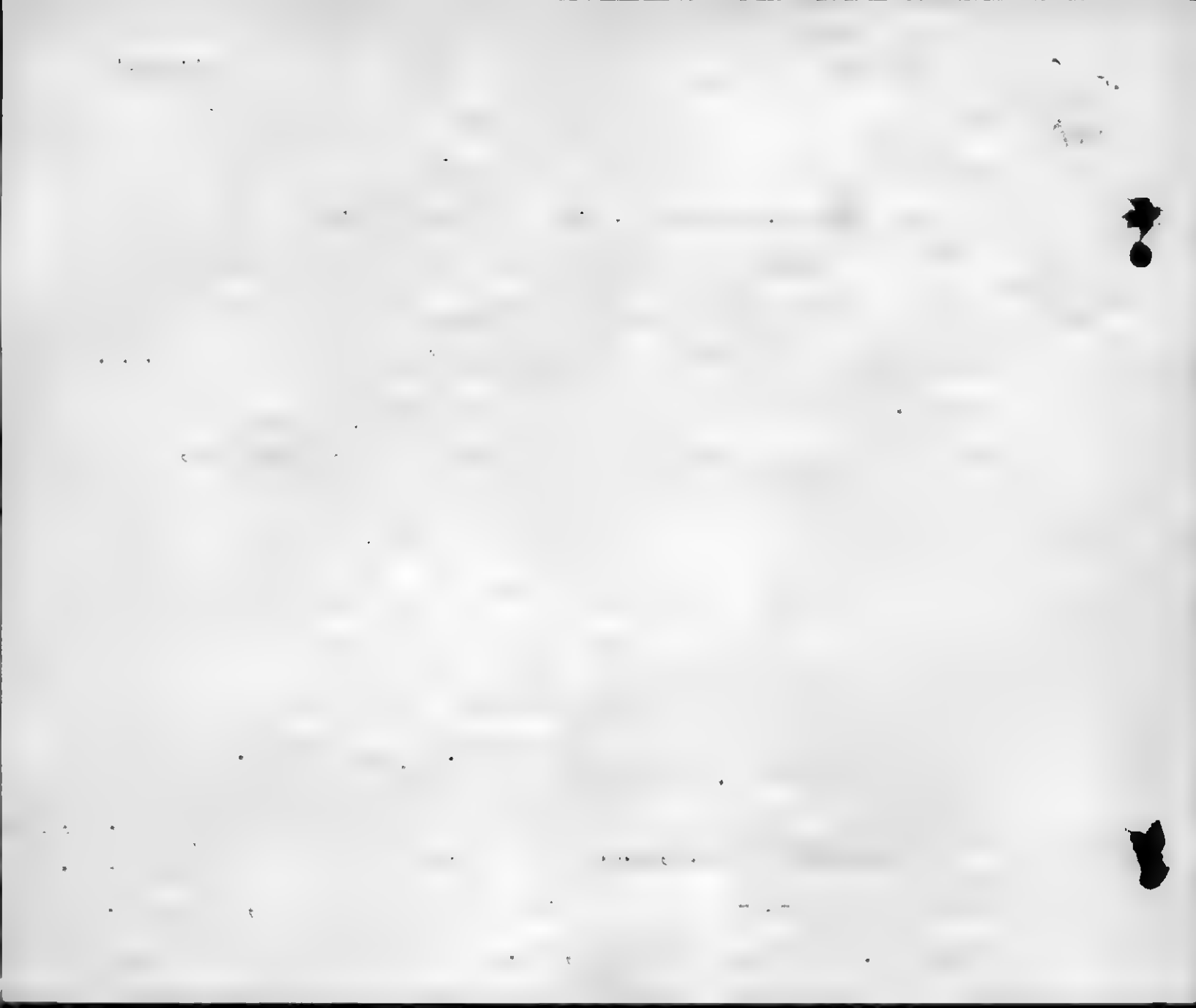
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12877

12862

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN b <u>69 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Norfolk</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Norfolk</u> d. STREET ADDRESS <u>879 Justis Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Gerald Wayne Patterson</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>November 18 1961</u>	
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>	
<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>13 March, 1957</u>		<b>9. AGE</b> (In years last birthday) <u>4</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None (child)</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Virginia</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Joseph T. Patterson</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Juan Cooke</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give number of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>	
<b>17. INFORMANT</b> <u>The Medical Record</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Edema</u> DUE TO (b) <u>Acute lymphocytic leukemia</u> DUE TO (c) <u>11 months</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).</b>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. City or town</b> (County) (State)	
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>10 Sept. 1961</u> to <u>18 Nov. 1961</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>18 Nov. 1961</u> , and that death occurred at <u>1:31 AM</u> from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <u>Frederick H. Welland</u> M.D. <b>22c. PHYSICIAN'S NAME</b> (Type) <u>Frederick H. Welland</u>		<b>22b. DATE SIGNED</b> <u>Nov. 18, 1961</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial-transit 11-19-61</u>		<b>23b. DATE THEREOF</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Forest Lawn Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Norfolk, Virginia.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>ROBERT A. PUMPHREY</u>		<b>25. REC'D BY REGISTRAR</b> <u>NOV 22 '61</u>	
<b>25a. ADDRESS</b> <u>Bethesda, Md.</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>C. H. S. House</u>	



TO BE FILLED BY THE ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

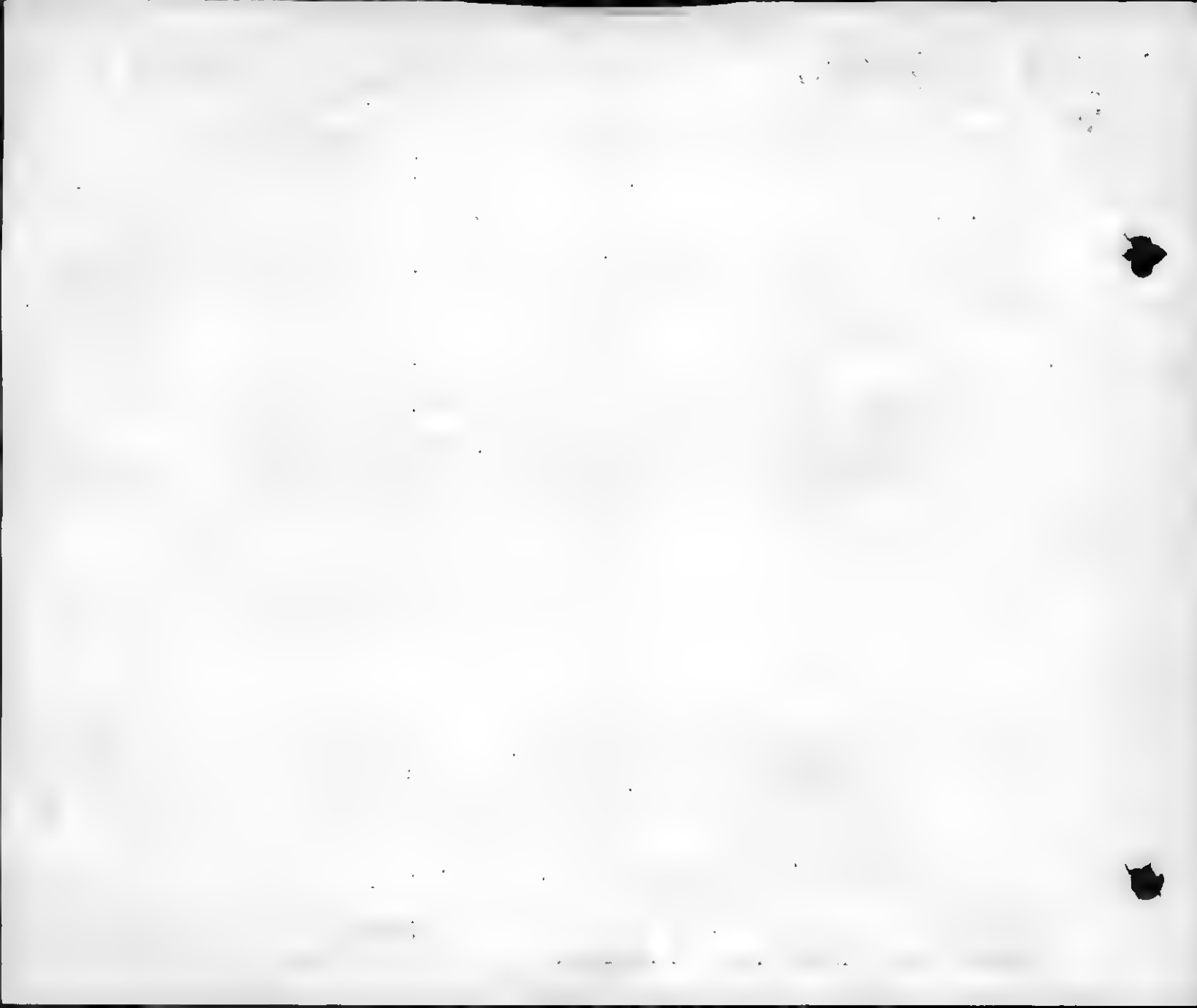
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12878

12864

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Virginia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Falls Church</b>	
c. LENGTH OF STAY IN lb <b>3 days</b>		d. STREET ADDRESS <b>1001 Barrett Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Elva Florence Perrin</b>		4. DATE OF DEATH Month <b>November</b> Day <b>21</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 4, 1901</b>
9. AGE (In years last birthday) <b>60 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Indiana</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Kemp</b>		14. MOTHER'S MAIDEN NAME <b>Rose Sanders</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown). (If yes give war and dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Daughter: Roas Ann McCoy, Same as #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Lung</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from <b>Nov. 19, 1961</b> , to <b>Nov. 21, 1961</b> , that (b) (we) last saw the deceased alive on <b>Nov. 21, 1961</b> , and that death occurred at <b>6:45 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>John W. Brackett</b> M.D.		22b. DATE SIGNED <b>November 21, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN W. BRACKETT, LT MC USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/21/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Fairfax Memorial Gardens</b>		23d. LOCATION (City, town or county) (State) <b>Fairfax, Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Everly Funeral Home, W. Main St., Fairfax, Va.</b>		25. REGISTRAR'S SIGNATURE <b>NOV 24 1961</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

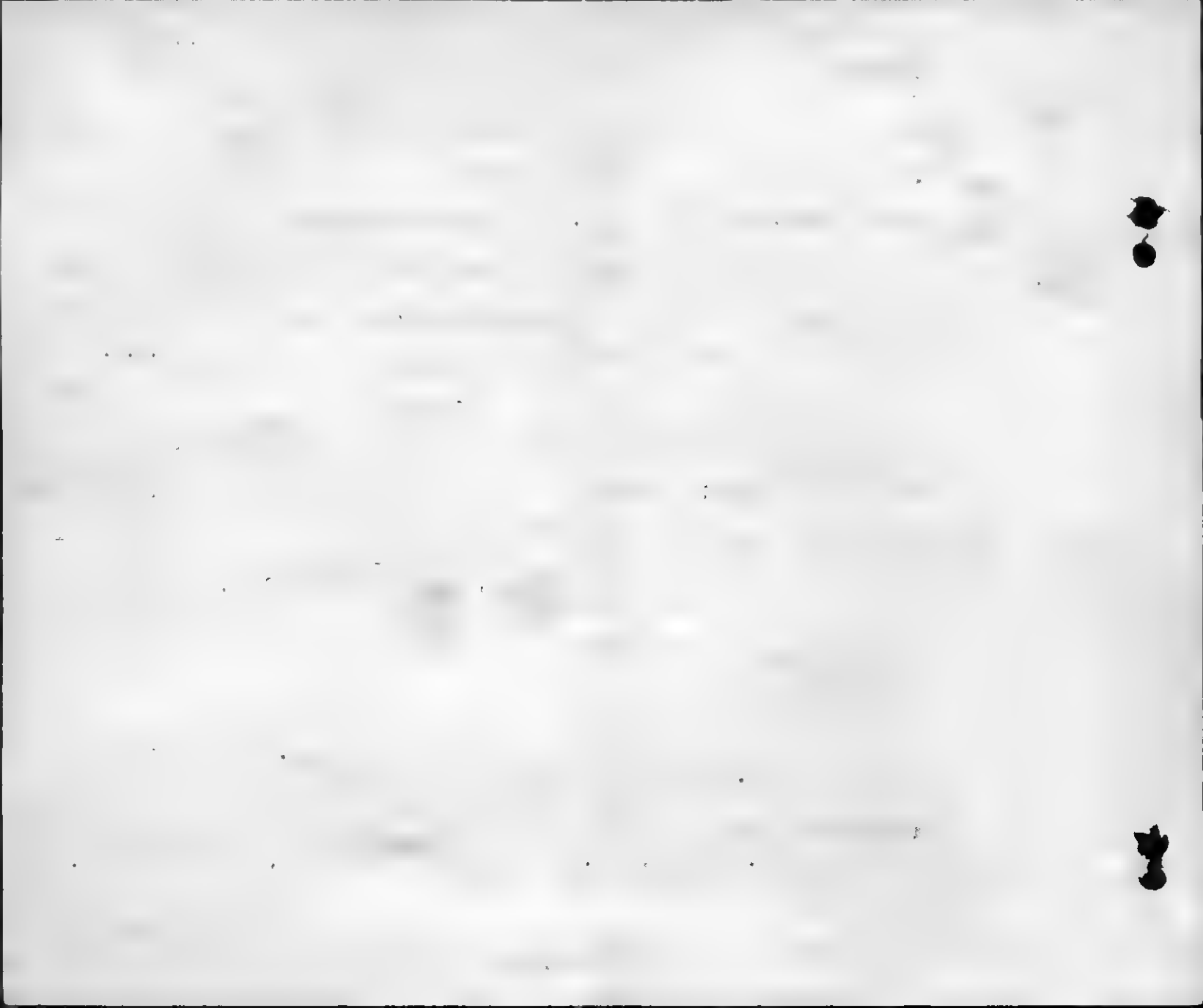
12879		Item 23b, Film G501 11/24/61 ink		12865	
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. LENGTH OF STAY IN TB <u>1 hr. 32 min.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>		e. STATE <u>D. C.</u>		f. COUNTY <u>Washington</u>	
3. NAME OF DECEASED (Type or print) <u>Baby Boy Peterson</u>		4. DATE OF DEATH <u>November 15, 1961</u>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>November 15, 1961</u>		9. AGE (In years last birthday) <u>1</u> yrs.		10. IF UNDER 1 YEAR <u>1</u> Months <u>1</u> Days <u>32</u> Hours <u>32</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>- - - - -</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - - - -</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Bethesda, Md.</u>	
13. FATHER'S NAME <u>Dale Carlton Peterson</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Jeanne Little</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>- - - - -</u>		16. SOCIAL SECURITY NO. <u>- - - - -</u>		17. INFORMANT <u>FATHER: Dale C. Peterson, same as 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>prematurity</u> 774X DUE TO (b) <u>- - - - -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>- - - - -</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs.</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>absent abdominal muscles, oligoamnios, multiple congenital anomalies</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>- - - - -</u>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>-</u> p.m. <u>-</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>- - - - -</u>	
20f. (City or town) <u>- - - - -</u>		20g. (County) <u>- - - - -</u>		20h. (State) <u>- - - - -</u>	
21. I certify that (this hospital) attended the deceased from <u>November 15, 1961</u> to <u>November 15, 1961</u> that (we) last saw the deceased alive on <u>November 15, 1961</u> , and that death occurred at <u>1:37 AM</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>G. B. Avery</u>		22b. DATE SIGNED <u>November 15, 1961</u>		22c. PHYSICIAN'S NAME (Type) <u>G. B. AVERY LT MC USA</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/20/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	
23d. LOCATION (City, town or county) <u>Rockville, Md.</u>		23e. (State) <u>Md.</u>		23f. (Country) <u>USA</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. A. PUMPHREY</u>		24a. ADDRESS <u>R. A. PUMPHREY Funeral Home, Bethesda, Md.</u>		24b. DATE <u>NOV 21 '61</u>	
25a. REC'D BY REGISTRAR <u>- - - - -</u>		25b. REGISTRAR'S SIGNATURE <u>- - - - -</u>		25c. DATE <u>- - - - -</u>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. The law requires that the death certificate be examined within 24 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
12880  
12866  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 85 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Arizona b. COUNTY Tempe c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 1707 Apache Boulevard d. STREET ADDRESS 4182		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William Edward Pike		4. DATE OF DEATH Month Day Year November 20 19 61		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Min. September 12, 1911 20 yrs.	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fish cutter		10b. KIND OF BUSINESS OR INDUSTRY unemployed		11. BIRTHPLACE (County & State, or foreign country) Massachusetts	
13. FATHER'S NAME Valence Pike		14. MOTHER'S MAIDEN NAME Evelyn Jones		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Not available		17. INFORMANT The Medical Records The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4.3 DUE TO (b) Cerebral anoxia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Post operative embolism, after correction of atrial septal defect. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (e) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 2 of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH Immediate Indeterminate 72 hours			
21. I certify that (X) (this hospital) attended the deceased from Aug. 27, 1961 to Nov. 20, 1961 that (X) (we) last saw the deceased alive on Nov. 20, 1961, and that death occurred at 9:17 PM from the causes and on the date stated above.		22a. SIGNATURE Joseph W. Gilbert, M.D. 22c. PHYSICIAN'S NAME (Type)		22b. DATE SIGNED November 22, 1961 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal 23b. DATE OF REMOVAL 11/23/61		23c. NAME OF CEMETERY OR CREMATORY -		23d. LOCATION (City, town or county) Tempe, Ariz	
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co.		25a. REC'D BY REGISTRAR DATE NOV 27 '61		25b. REGISTRAR'S SIGNATURE W. W. Chambers	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

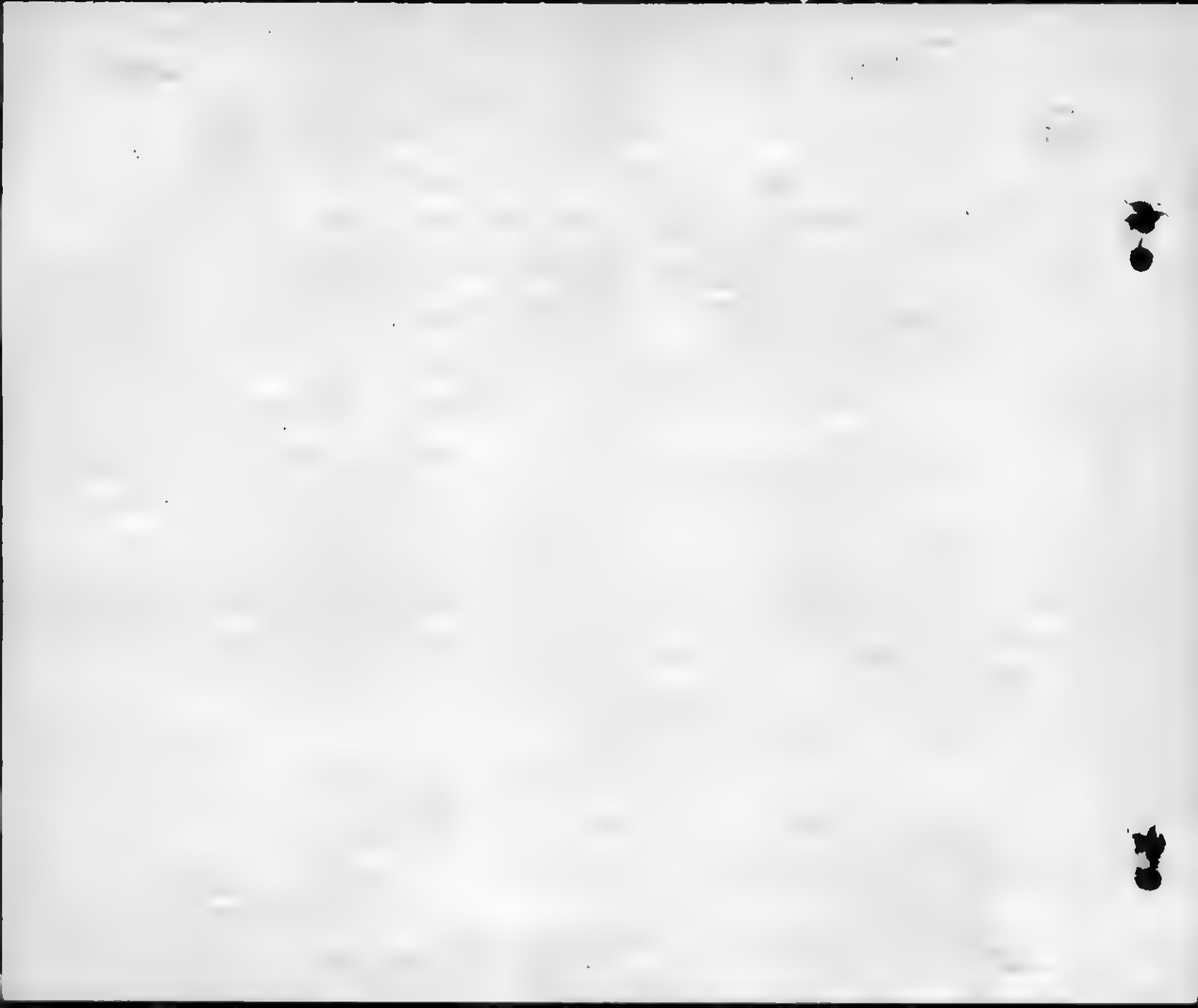
12881

12867

FOR STATE  
HEALTH DEPT.

TO DEPARTMENT OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>07 Gaithersburg</u>	
c. LENGTH OF STAY IN 1b <u>years</u>		d. STREET ADDRESS <u>13 W. Selwyn Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>13 W. Selwyn Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Milton Pope</u>		4. DATE OF DEATH <u>Nov 6 1961</u>	
5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>5-22-79</u>	
9. AGE (In years last birthday) <u>82 yrs</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Joseph Pope</u>		14. MOTHER'S MAIDEN NAME <u>Matilda Thompson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>5-22-79</u>	
17. INFORMATION <u>How nobly - Gaithersburg md</u>		INTERVAL BETWEEN ONSET AND DEATH <u> sudden</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>7201</u> DUE TO (c) <u>Due to</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Due to</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
SIGNATURE <u>Frank J. Broschert</u>		DATE SIGNED <u>11-6-61</u>	
NAME (Type) <u>FRANK J. Broschert</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-8-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Joshua</u>		22d. LOCATION (City, town, or country) (State) <u>Gaithersburg md</u>	
23. FUNERAL DIRECTOR <u>Ernest C. Gaithersburg</u>		24a. REC'D BY REGISTRAR <u>NOV 8 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

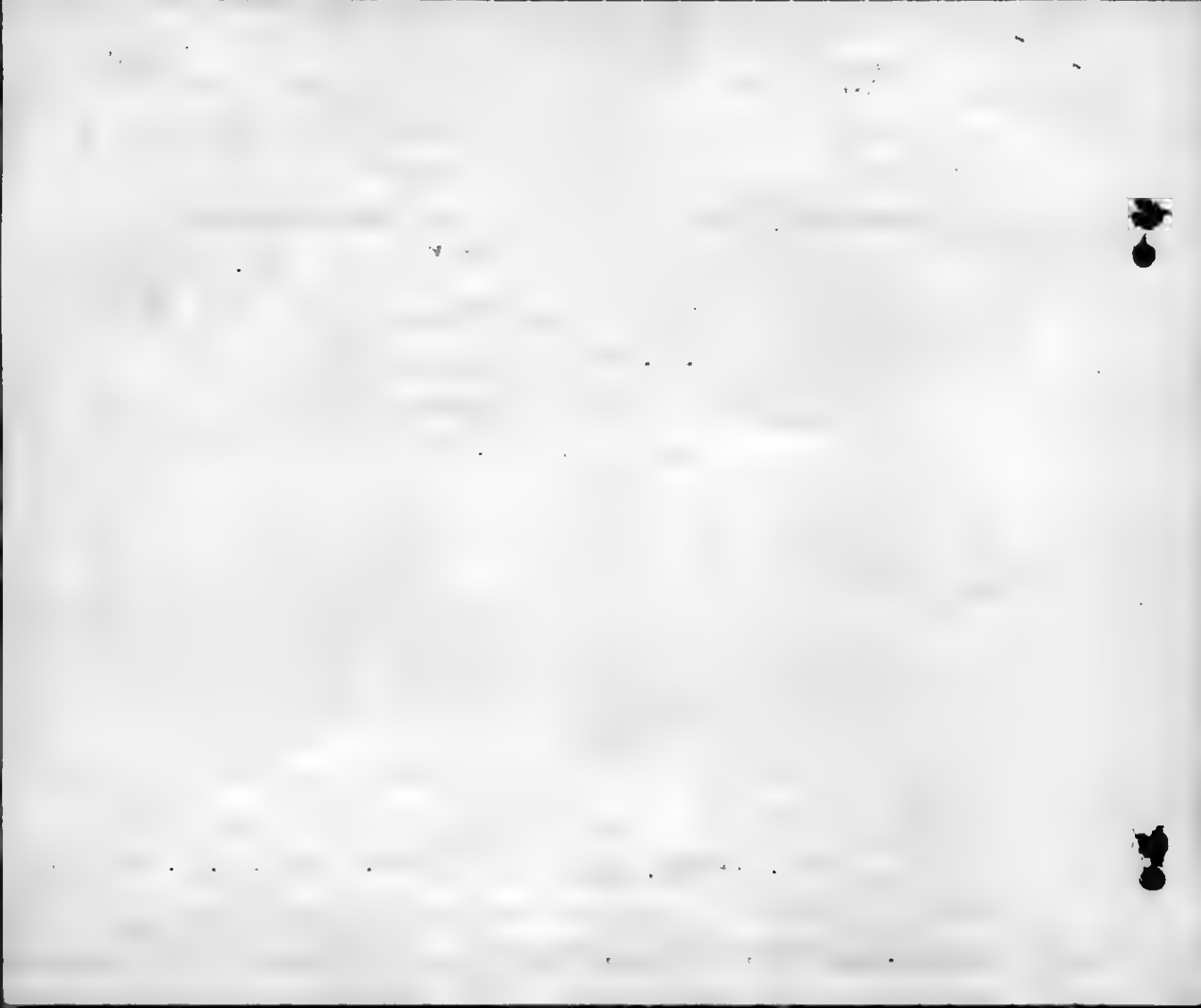
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12882

12868

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN b. <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6216 Walhounding Road</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>58 Bethesda</u> d. STREET ADDRESS <u>6216 Walhounding Road</u>	
3. NAME OF DECEASED (Type or print) <u>Alden A. Potter</u> 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>10/12/84</u> 8. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Gvt</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Minnesota</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>28</u> Year <u>19 61</u> 9. AGE (In years last birthday) <u>77</u> yrs. IF UNDER 1 YEAR: Months <u>1</u> Days <u>16</u> Hours <u></u> Min. <u></u> 13. FATHER'S NAME <u>Alden H. Potter</u> 14. MOTHER'S MAIDEN NAME <u>Unknown</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Lloyd A. Potter-Son, Bethesda, Maryland</u> Address <u></u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic Heart Disease</u> (a), stating the underlying cause last. DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u> <u>7 years.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u></u> p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u> 20f. (City or town) (County) (State) <u></u>		21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> , 19 <u></u> , to <u>Nov 28</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Nov 22, 1961</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above. 22a. SIGNATURE <u>John W. Latimer, Jr</u> 22b. PHYSICIAN'S NAME (Type) <u>John W. Latimer, Jr</u> 22c. DATE <u>11/28/61</u> 22d. ADDRESS <u>1728 Mass. Avenue, N. W. Wash DC</u> 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22f. DATE SIGNED <u>11/28/61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> 23b. DATE THEREOF <u>11/29/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u> 23d. LOCATION (City, town or county) (State) <u>Suitland, Maryland</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u> ADDRESS <u></u> 25a. REC'D BY REGISTRAR <u>DEC 1 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Robert A. Pumphrey</u>	



## CERTIFICATE OF DEATH

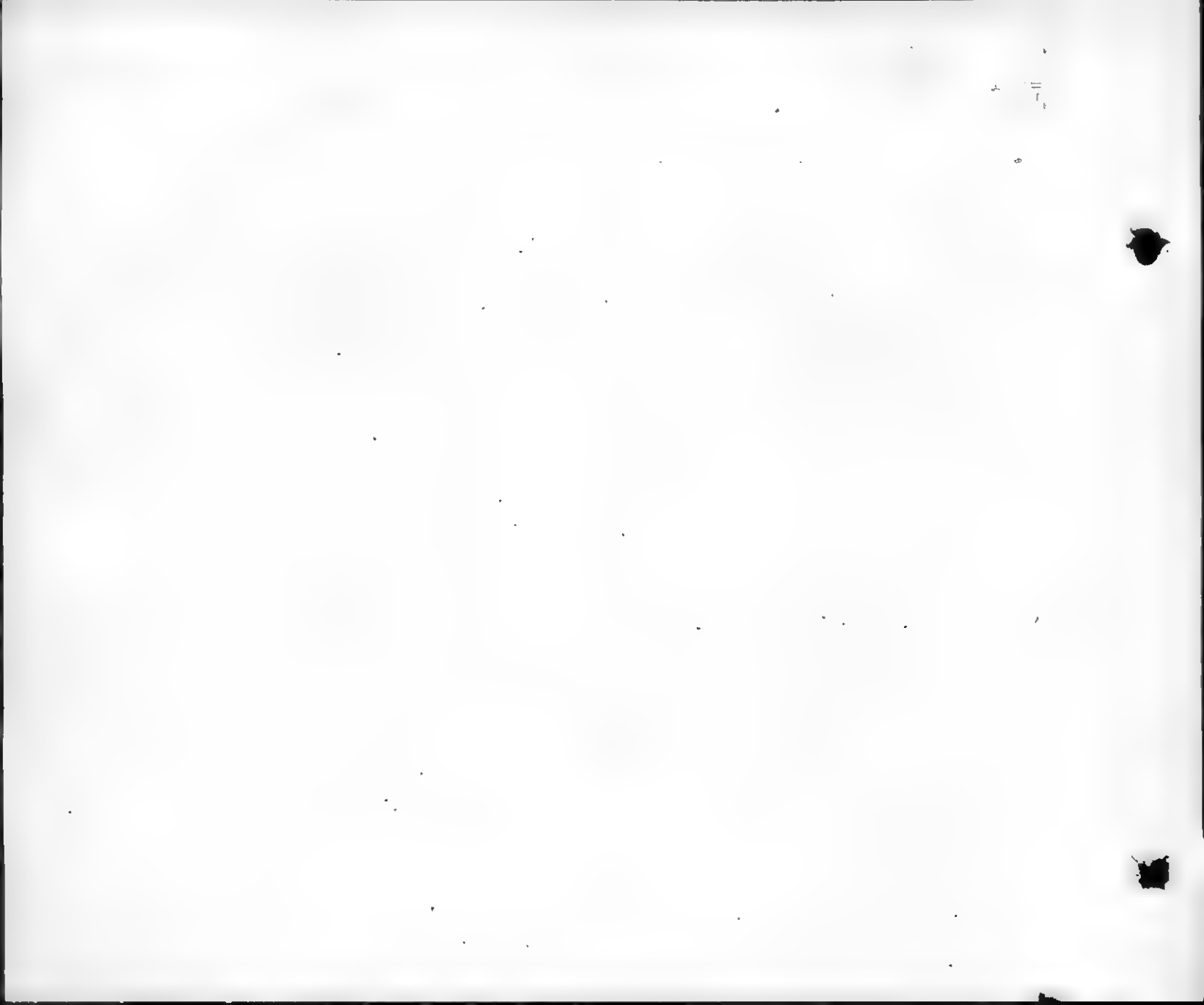
Reg. Dist. No. 12862

12883

1. PLACE OF DEATH a. COUNTY <u>BEL PRE NURSING HOME</u> <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington DC</u>	
c. LENGTH OF STAY IN 1b <u>22 DAYS</u>		d. STREET ADDRESS <u>1500 MASS. AVE. NW</u>	
d. NAME OF HOSPITAL (If not a hospital, give street address) OR INSTITUTION <u>BEL PRE NURSING HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRIDA RADEZY</u>		4. DATE OF DEATH Month Day Year <u>11 24 1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 27, 1877</u>
9. AGE (In years last birthday) <u>84</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H. W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NEW YORK</u>	
11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>SIMON HAY</u>		14. MOTHER'S MAIDEN NAME <u>BETTY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>140</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular Thrombosis</u> <u>332X</u> DUE TO (b) <u>Generalized Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CANCER of the Colon</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u>	
18. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/2</u> , 19 <u>61</u> , to <u>11/24</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>11/24</u> , 19 <u>61</u> , and that death occurred at <u>5:20 P.M.</u> from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Max G. Sherer MD</u>		ADDRESS (Street, city or town, state) <u>2025 Eye Street NW</u>	
PHYSICIAN'S NAME (Type) <u>MAX G. SHERER, MD</u>		DATE SIGNED <u>11/24/61</u>	
22a. BURIAL INFORMATION (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>NOV. 26, 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>NEW MT. CARMEL CEMETARY</u>	22d. LOCATION (City, town, or county) (State) <u>NV</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Langansky</u>		24a. REC'D BY REGISTRAR <u>NOV 28 '61</u>	
ADDRESS <u>3501-14th St. NW</u>		24b. REGISTRAR'S SIGNATURE <u>William L. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



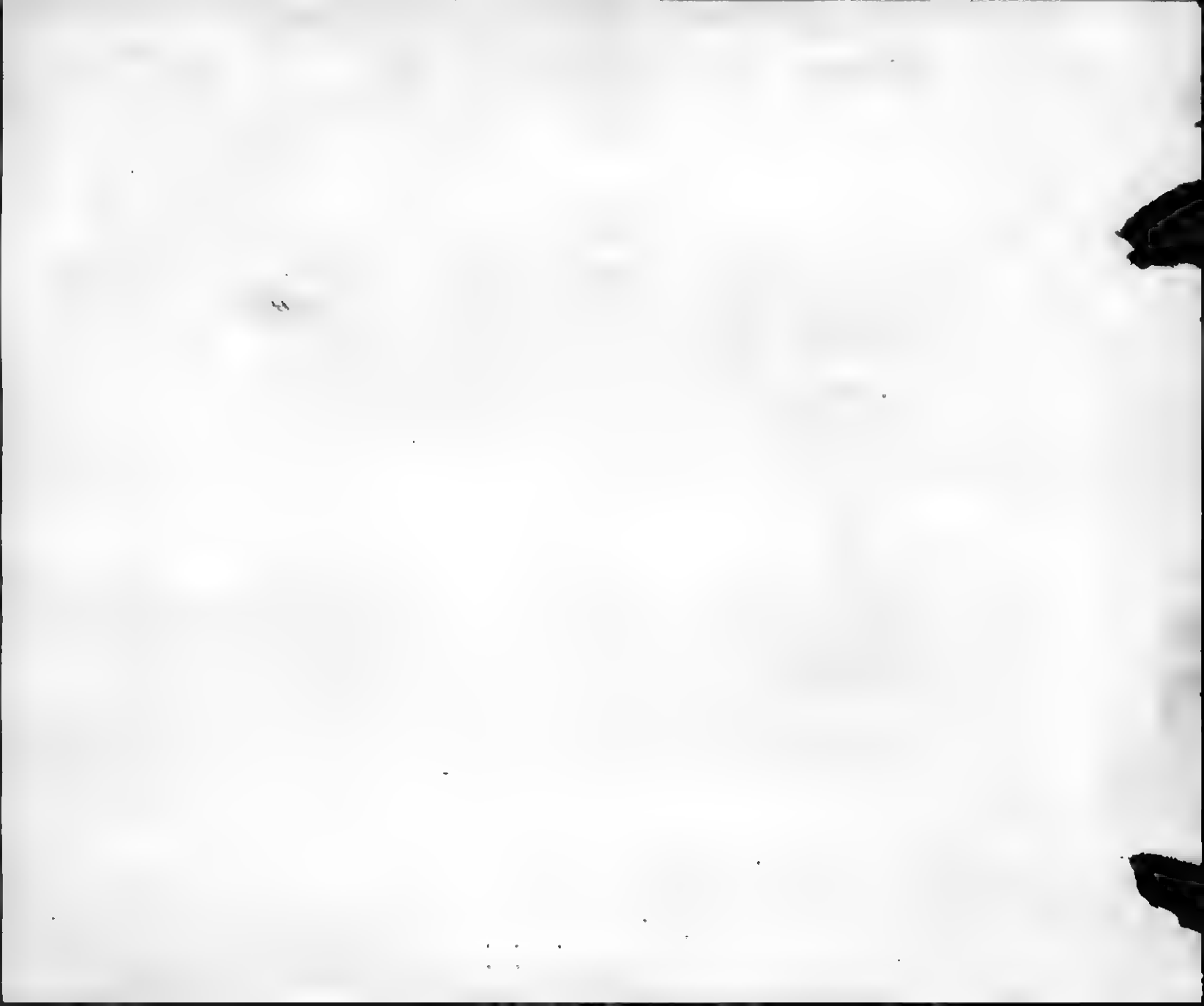
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u> 41X	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3812 Livingston St. N.W. D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Arthur Woodland Nursing Home</u>		d. STREET ADDRESS <u>3812 Livingston St. N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>LEILA</u> First Middle Last <u>L. RAND</u>	4. DATE OF DEATH Month <u>11</u> Day <u>22</u> Year <u>1961</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 18, 1866</u> 9. AGE (In years last birthday) <u>94</u> 10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HWF</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John B. Rand</u>		14. MOTHER'S MAIDEN NAME <u>Victoria Cheek</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>none</u>	
17. INFORMANT <u>Philinda R. Anglemeyer</u> Address <u>same as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Left ventricular cardiac failure</u> DUE TO (c) <u>Arteriosclerotic heart disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>1 month</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 17</u> , 19 <u>61</u> , to <u>22 Nov.</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>17 Nov.</u> , 19 <u>61</u> , and that death occurred at <u>6:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Seruch T. Kimble</u> M.D. <u>927 Penshurst Dr., Silver Spring, Md.</u>		DATE SIGNED <u>11-22-61</u>	
PHYSICIAN'S NAME (Type) <u>Seruch T. Kimble</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>	22b. DATE THEREOF <u>11/24/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u>	22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co. Washington 9, D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 24 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>

TO FURNISH TO THE REGISTRAR: The low requires that the death certificate be executed within 72 hours after death. Page 4 may be detached for use as the burial-transit permit. After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# FOR STATE HEALTH DEPT.

TO LOCALITY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 4 and 5 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 12 hours after death.

VS. A15ME  
5M 9/60

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 12885 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12371

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
c. LENGTH OF STAY IN 1b <u>38 yrs</u>		d. STREET ADDRESS <u>37 Philadelphia</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>37 Philadelphia Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Evelyn Alice Reaney</u>		4. DATE OF DEATH <u>Nov 20 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-25-15</u>
9. AGE (In years last birthday) <u>46</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S. - Ga.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. - Ga.</u>	
13. FATHER'S NAME <u>L. Reaney</u>		14. MOTHER'S MAIDEN NAME <u>Alice Shaver</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes U.S. Marine</u>		16. SOCIAL SECURITY NO <u>2-252-15</u>	
17. INFORMANT <u>Otto B Roepke - Item 2</u>		Address <u>Stun 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Barbiturate Poisoning</u> 7778 Conditions, if any, which gave rise to immediate cause (b) <u>Due to</u> (c) <u>Due to</u> cause listed.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brosehaent</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BROSEHAENT</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 21-1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Edgar Hill Cemetery Prince George Co - Md.</u>		22d. LOCATION (city, town, or county) (State) <u>11-21-61</u>	
22e. ADDRESS <u>357 Carroll St. N.E. Takoma Park - D.C.</u>		24a. REC'D BY REGISTRAR <u>Nov 24 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur K. Ketter</u>		24c. REGISTRAR'S SIGNATURE <u>Arthur K. Ketter</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12886

## CERTIFICATE OF DEATH

12872

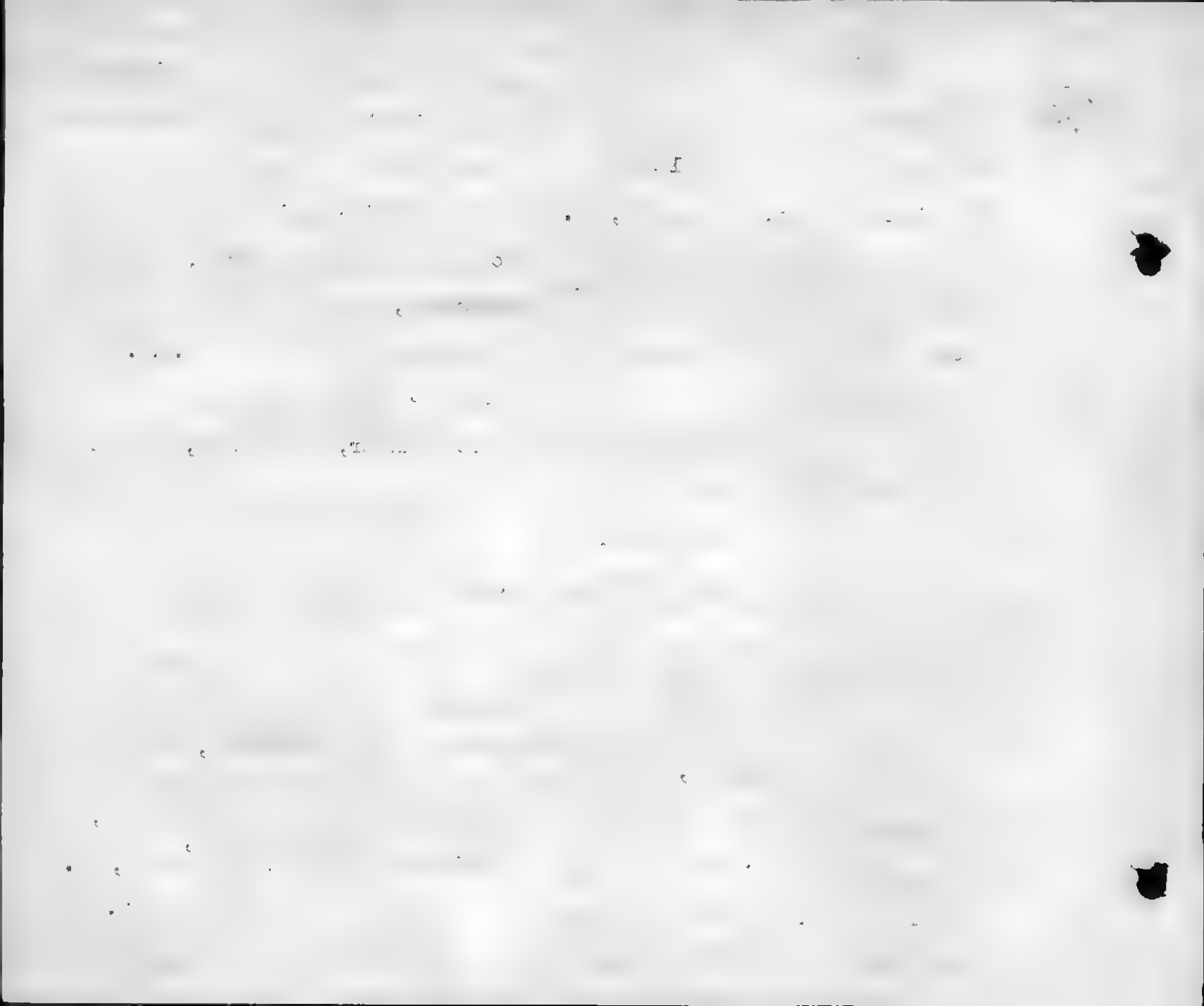
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>1 Day</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oxon Hill</b> d. STREET ADDRESS <b>4415 Brockton Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Annie Mae Rennoe</b> First Middle Last		<b>4. DATE OF DEATH</b> <b>November 4, 1961</b> Month Day Year	
<b>5. SEX</b> <b>Female</b> <b>6. COLOR OR RACE</b> <b>White</b> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>February 14, 1902</b> last birthday <b>59</b> yrs <b>59</b> Months <b>14</b> Days <b>19</b> Hours <b>14</b> Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>None</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>None</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Virginia</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>William Rennoe</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Minnie Cornell</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> <b>No</b> (Yes, no, or unknown) (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>Unascertainable</b> <b>17. INFORMANT</b> <b>The Medical Records</b> <b>The Clinical Center, Bethesda 14, Maryland</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Sepsis</b> <b>204.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Broncho pneumonia</b> (c) <b>Acute Myelogenous leukemia</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1 week</b> <b>1 week</b> <b>3 months</b>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> <b>20d. INJURY OCCURRED</b> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) Hour a.m. <b>7:45</b> <b>20f. (City or town)</b> <b>Manassas</b> <b>(County)</b> <b>Manassas</b> <b>(State)</b> <b>Va.</b> p.m.			
<b>21. I certify that</b> <b>XX</b> (this hospital) attended the deceased from <b>November 3, 1961</b> , to <b>November 4, 1961</b> , that (s) (we) last saw the deceased alive on <b>November 4, 1961</b> , and that death occurred at <b>7:45 PM</b> , from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>Edward S. Henderson</b> <b>22c. PHYSICIAN'S NAME</b> (Type) <b>Edward S. Henderson</b>		<b>22b. DATE SIGNED</b> <b>November 6, 1961</b> <b>22d. ADDRESS</b> <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b> <b>23b. DATE THEREOF</b> <b>Nov. 7 1961</b> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Manassas</b>		<b>23d. LOCATION</b> (City, town or county) <b>Manassas</b> <b>(State)</b> <b>Va.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>ADDRESS</b> <b>Brooks Sons</b> <b>Hyattsville, Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>DATE</b> <b>NOV 10 61</b> <b>Charles S. Frank</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. The law requires that the death certificate be completed within 24 hours after death. The law requires that the death certificate be completed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

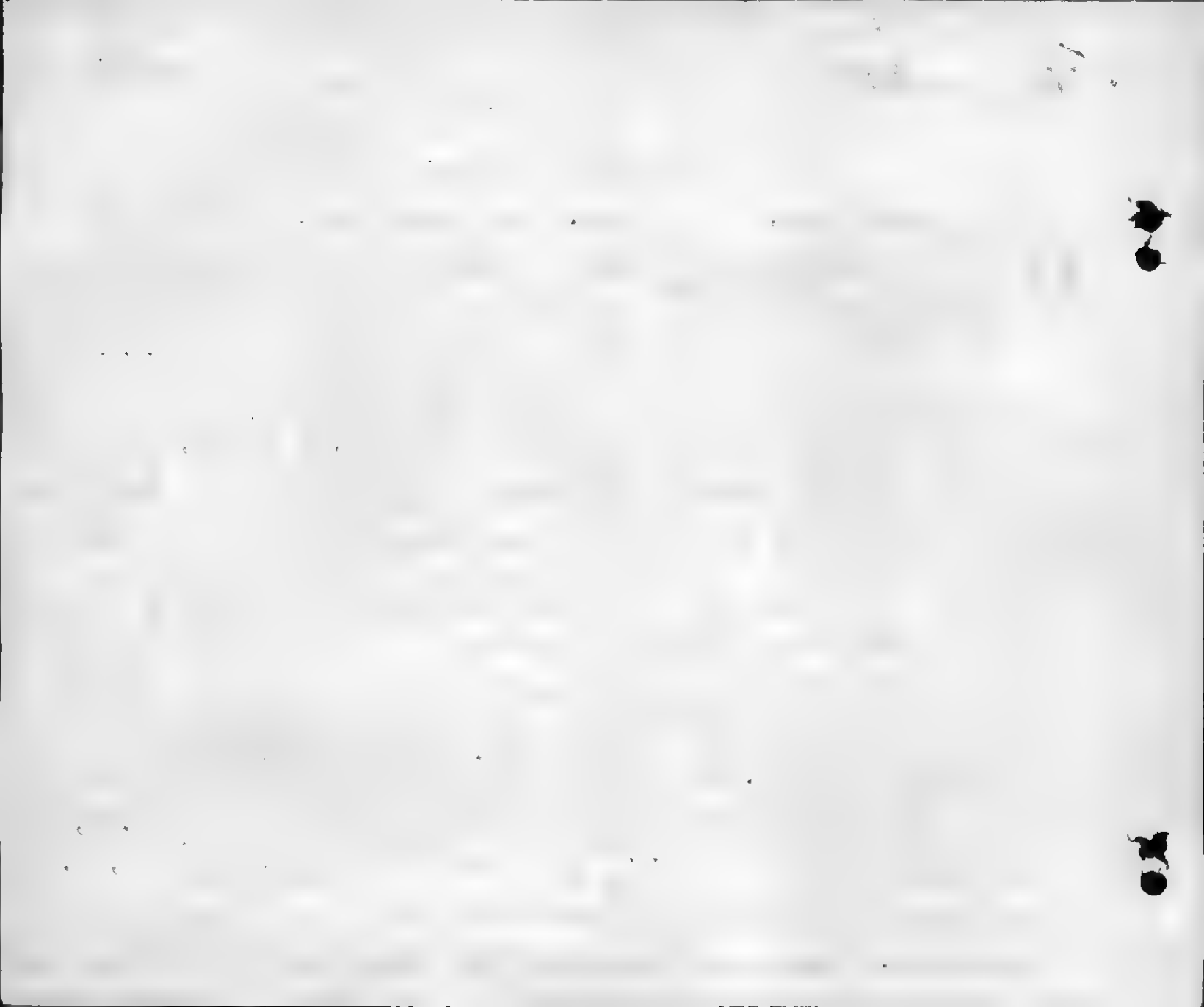
12887

12873

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>153 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maine</b> b. COUNTY <b>Portland</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>57X-3</b> d. STREET ADDRESS <b>270 Brackett Street</b>	
3. NAME OF DECEASED (Type or print) <b>Patrick Francis Ridge</b>		4. DATE OF DEATH Month <b>November</b> Day <b>19</b> Year <b>1961</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 14, 1909</b>	
10a. MALE OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Yard conductor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None (retired)</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maine</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Michael Ridge</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Ridge</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unavailable</b>	
17. INFORMANT <b>The Medical Record</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary artery Heart Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Reticulum Cell Sarcoma</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>Less than one hour</b> <b>YEARS</b>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <b>Jun. 19, 1961</b> to <b>Nov. 19, 1961</b> , that (we) last saw the deceased alive on <b>Nov. 19, 1961</b> , and that death occurred at <b>1:30 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Michael Field</b>		22b. DATE SIGNED <b>Nov. 20, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Michael Field, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Transit 11/21/61</b>		23b. DATE THEREOF <b>11/21/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>South Portland Calvary</b>		23d. LOCATION (City, town or county) (State) <b>South Portland, Maine</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>NOV 22 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. F...</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



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FOR STATE  
HEALTH DEPT

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, any page may be retained for your files. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12874											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>LaKoma Park</u> c. LENGTH OF STAY IN 1b <u>18 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash. Sanitarium &amp; Hosp</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton, Washington, D.C.</u> d. STREET ADDRESS <u>11901 Jefferson Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>SARAH F Rigney</u>		4. DATE OF DEATH <u>11 16 1961</u>		5. SEX <u>Fe</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-15-72</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (in years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>	
13. FATHER'S NAME <u>John Freese</u>				14. MOTHER'S MAIDEN NAME <u>Mary Evans</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war and dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Wash. San &amp; Hosp Record</u>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MASSIVE PULMONARY EMBOLISM</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) <u>BRONCHOPNEUMONIA</u> DUE TO (c) <u>FRACTURE LEFT HIP</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell to floor at Wheaton Nursing Home - fracture L hip</u>							
20c. TIME OF INJURY Month, Day, Year Hour <u>2:30 p.m.</u> <u>10-29 1961</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Nursing Home Wheaton monty Md</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>FRANK J. Bluschant</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>11-17-61</u>			
EXAMINER'S NAME (Type) <u>Frank J. Bluschant</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE TIME OF REMOVAL <u>Nov 20 1961</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem</u>			
22d. LOCATION (City, town, or country) <u>Wheaton Maryland</u>				22e. LOCATION (City, town, or country) (State)							
23. FUNERAL DIRECTOR <u>W. K. Huntemann &amp; Son</u>				ADDRESS <u>5732 Georgia Ave N. W. Washington D. C.</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			
24a. REC'D BY REGISTRAR				DATE <u>NOV 21 '61</u>							

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO PUBLIC HEALTH DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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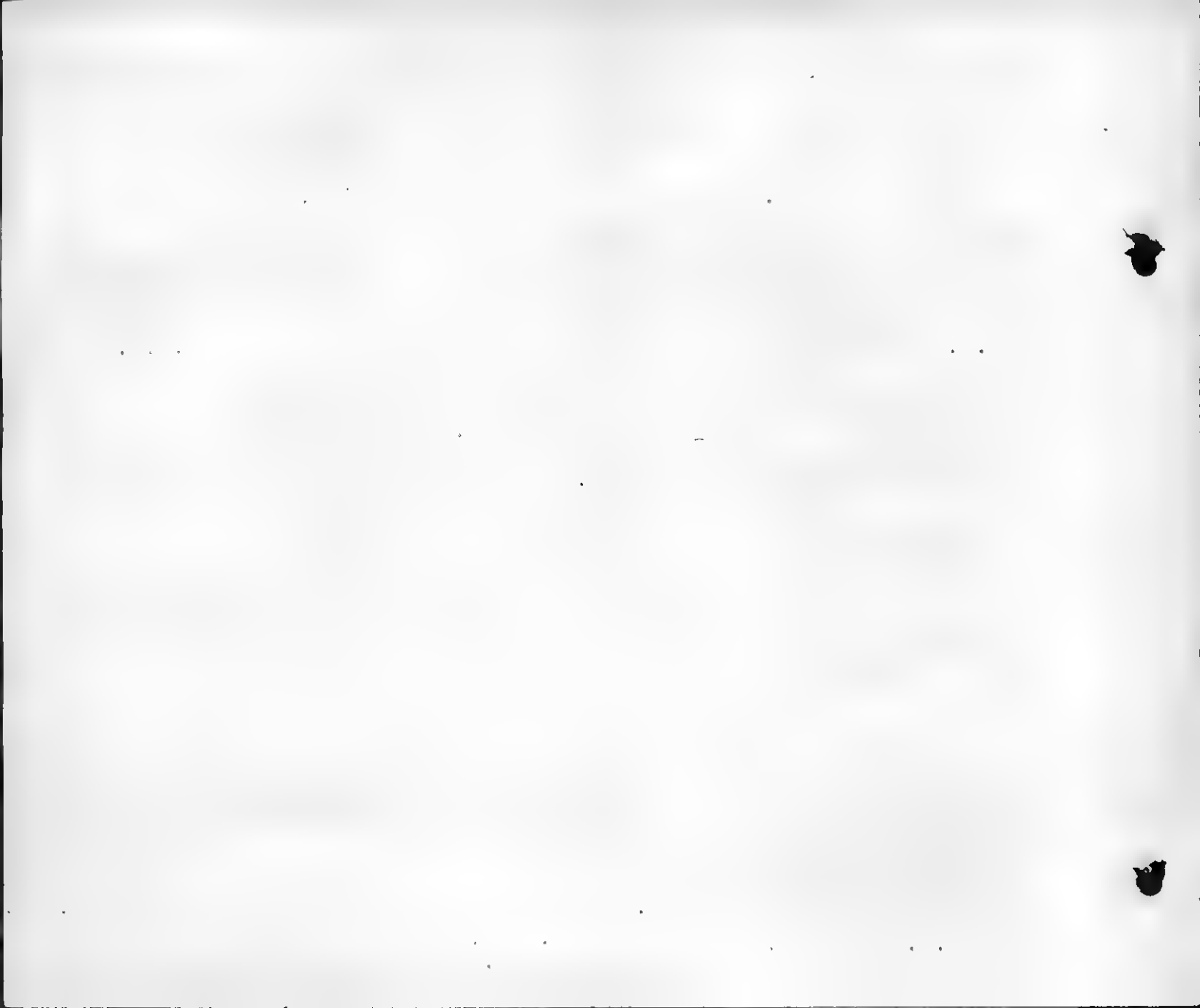
CERTIFICATE OF DEATH

Reg. Dist. No. 12875

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>28</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		d. STREET ADDRESS <b>9105 Louis Ave.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>9105 Louis Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Harry Lawrence Ritter</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>29</b> Year <b>1961</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/1/02</b>
9. AGE (In years last birthday) <b>59</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>D.C. Transit Receiver of Revenue</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Barton Ritter</b>		14. MOTHER'S MAIDEN NAME <b>Adelaide Hamilton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>518-10-5631</b>	
17. INFORMANT <b>Agnes C. Ritter same as #2</b>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary heart ds., RBBB, angina, old infarction years</b> (c) <b>Carcinoma of bladder, recto-abdominal fistula 3 months</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Old Pulmonary tuberculosis, Old Peptic ulcer</b>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <b>Silver Spring, Md.</b>		(County) (State)
21. I certify that I attended the deceased from <b>Aug. 1946</b> to <b>Nov. 29, 1961</b> , that I last saw the deceased alive on <b>Nov. 24, 1961</b> , and that death occurred at <b>10 A.M.</b> from the causes and on the date stated above.		
ACTUAL SIGNATURE <b>Sydney Leventhal</b> M.D. <b>9710 Colville Rd., Silver Spring, Md.</b>		DATE SIGNED <b>11/29/61</b>
PHYSICIAN'S NAME (Type) <b>Sydney Leventhal</b>		

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>	22b. DATE THEREOF <b>11/30/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Crematory</b>	22d. LOCATION (City, town, or county) (State) <b>Prince Georges County, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>		24a. REC'D BY REGISTRAR <b>2901 14th St. N.W.</b> <b>Washington 9, D.C.</b>	24b. REGISTRAR'S SIGNATURE <b>DATE DEC 1 '61</b>



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

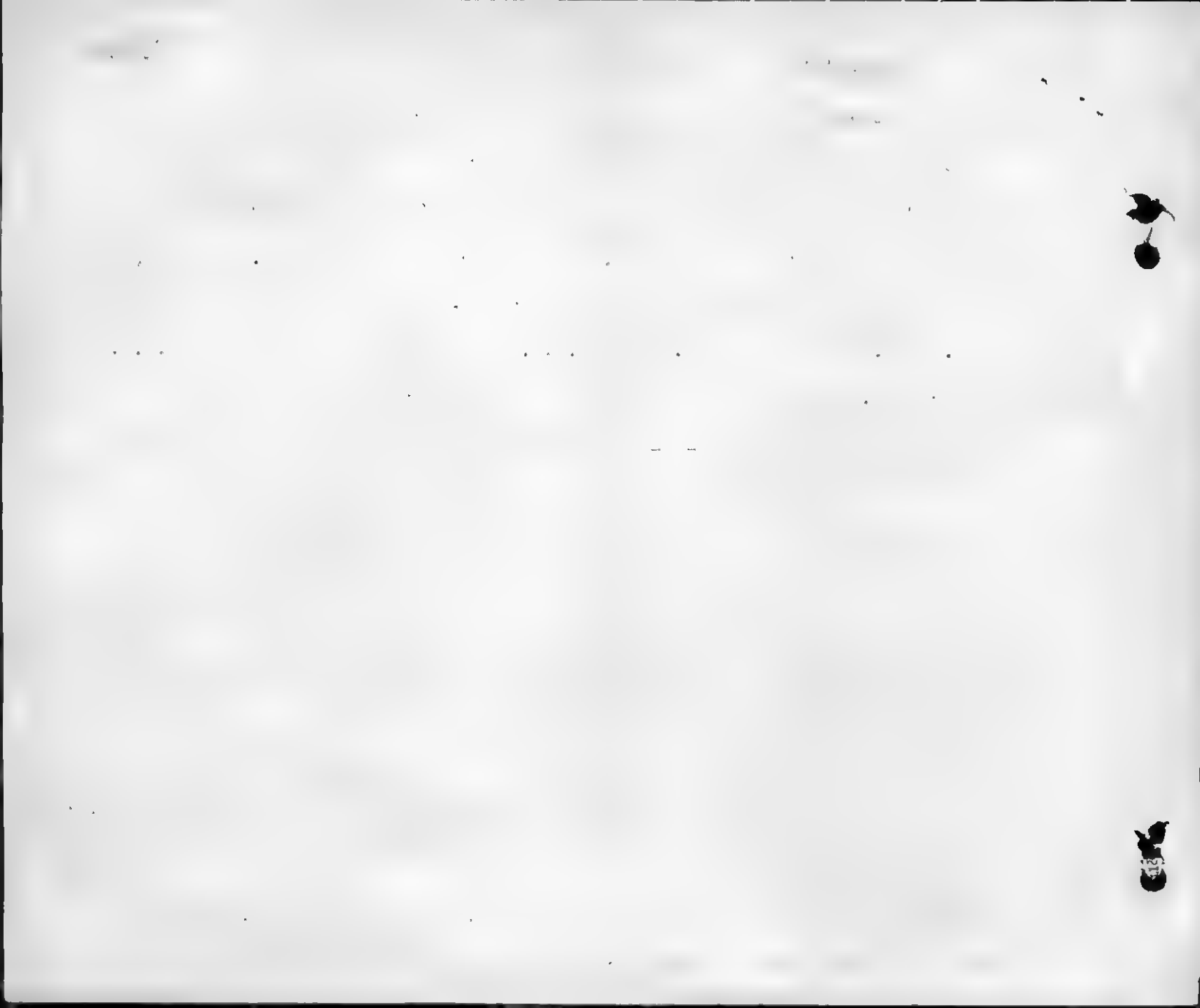
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<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY in 1b <u>24 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u> d. STREET ADDRESS <u>3502 Preston Court</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) <u>Robert J. Rogers</u>		<b>4. DATE OF DEATH</b> Month <u>Nov.</u> Day <u>12,</u> Year <u>19 61</u>									
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>June 4, 1905</u>								
<b>9. AGE</b> (In years last birthday) <u>56</u> yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td></td> <td>Hours</td> </tr> <tr> <td></td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days		Hours		Min.	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Sec. Tres.</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Hosp. Plan U.F.P.C.</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Nebraska</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.										
Months	Days										
	Hours										
	Min.										
<b>13. FATHER'S NAME</b> <u>Patrick J. Rogers</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Irwin</u>									
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>390-12-3791</u>		<b>17. INFORMANT</b> <u>Bernice Rogers (wife)</u> Address <u>same as above</u>									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO (b) <u>Concussion, The Lung</u> (c) <u>cause last.</u> PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>INTERVAL BETWEEN ONSET AND DEATH</u>											
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>11/12/61</u> Hour a.m. <u>19</u> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)									
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>10/1/61</u> <b>to</b> <u>11/12/61</u> <b>that (I) (we) last saw the deceased alive on</b> <u>10/11/61</u> <b>and that death occurred at</b> <u>9:11 A.M.</u> <b>from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <u>Walter A. Kelly</u> M.D.		<b>22b. DATE SIGNED</b> <u>11/12/61</u>									
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>W.H. Killax</u>		<b>22d. ADDRESS</b> <u>8218 Wisconsin Ave</u>									
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Bur-Transit 11/17/61</u>		<b>23b. DATE THEREOF</b>									
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Holy Cross Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Milwaukee, Wisconsin</u>									
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Pumphrey, Bethesda, Maryland</u>		<b>25a. REC'D BY REGISTRAR</b> <u>NOV 14 '61</u>									
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Hume</u>											

TO BE COMPLETED BY ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Pages 1 and 2 may be retained by the hospital - attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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**TO LOCALITY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. ~~Please~~ Execute this certificate, writing the word "panling" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by the funeral home.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Health Department. Page 4 should be used as a cremation permit. File page 1 and 2 with the State Health Department or its designated agent, prior to burial, cremation, or removal, and in any event within ~~72~~ 48 hours after death.

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<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>JAKIMA PARK DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 20</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San + Hosp.</u>		d. STREET ADDRESS <u>1002 OSAGE St.</u>	
3. NAME OF DECEASED (Type or print) <u>Robert Richard Rudy</u>		4. DATE OF DEATH Month <u>11</u> Day <u>20</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-26-25</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ARMY (U.S.A.) (Capt.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ARMY (U.S.A.) (Capt.)</u>	
11. BIRTHPLACE (State or foreign country) <u>Brookline Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>	
13. FATHER'S NAME <u>HENRY A.</u>		14. MOTHER'S MAIDEN NAME <u>VERA DOPKEEN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WWII</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>WIFE</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE is <u>Cardiac heart failure</u> <u>433.1</u> DUE TO <u>Cardiac arrhythmia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Interstitial myocarditis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u> <u>Sudden</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
SIGNATURE <u>Frank J. Broschak</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschak</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/21/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Washington</u>		22d. LOCATION (City, town, or county) (State) <u>Postland Maine</u>	
23. FUNERAL DIRECTOR <u>W.W. Chambers Co.</u>		24a. REC'D BY REGISTRAR <u>NOV 24 '61</u>	
ADDRESS <u>Washington</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. France</u>	



FOR STATE  
HEALTH DEPT.

TO DEPT. OF STATE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15M  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12892

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12878

1. PLACE OF DEATH a. COUNTY <b>Mont. Co.</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Mont.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN TB <b>1 hr 10 mins.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban</b>				d. STREET ADDRESS <b>R #1 Laytonsville</b>			
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>W.</b> Last <b>Saffell</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>11,</b> Year <b>19 61</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/3/81</b>		9. AGE (In years last birthday) <b>80</b> yrs. IF UNDER 1 YEAR: Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>La borer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sa nitary Comm.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryla nd</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Saffell</b>				14. MOTHER'S MAIDEN NAME <b>Betsy ?</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Maria n Ca rlisle /R.F.D. # 1 /Rockville</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>440X Acute Congestive heart failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Lobar pneumonia (ret.)</b> DUE TO (c) <b>day</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <b>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Hour <b>9</b> a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Frank J. Broschant</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>FRANK J. Broschant</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>11-14-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Forest Oak</b>	
22d. LOCATION (City, town, or country) (State) <b>Gaithersburg Md.</b>				22e. REGISTRAR'S SIGNATURE <b>Ernest C. Gartner</b>			
23. FUNERAL DIRECTOR <b>Ernest C. Gartner</b>				24. REC'D BY REGISTRAR <b>NOV 14 '61</b>			

MEDICAL CERTIFICATION

2

11-11-61



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

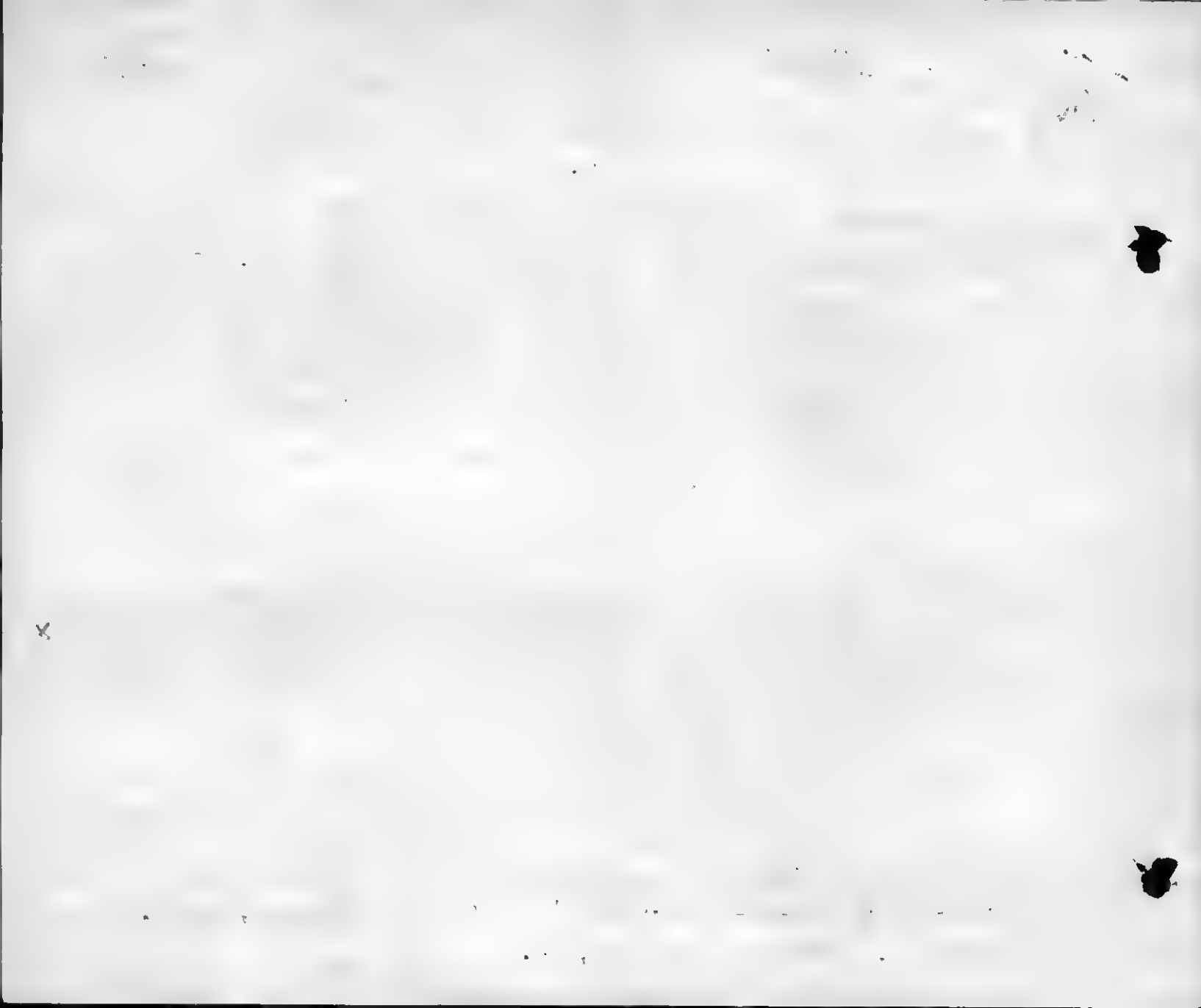
12893

## CERTIFICATE OF DEATH

12879

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN 1b <u>9 Hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SUBURBAN</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> d. STREET ADDRESS <u>5919 ROLSTON ROAD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>MICHAEL SAKSA</u> First Middle Last				<b>4. DATE OF DEATH</b> <u>Nov. 22 19 61</u> Month Day Year			
<b>5. SEX</b> <u>MALE</u>		<b>6. COLOR OR RACE</b> <u>WHITE</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>6/29/85</u>	
<b>9. AGE</b> (In years last birthday) <u>76</u> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Miner</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Coal</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Austria</u>	
<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A</u>		<b>13. FATHER'S NAME</b> <u>John Saksa</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Brutosky</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>	
<b>16. SOCIAL SECURITY NO.</b> <u>No</u>		<b>17. INFORMANT</b> <u>Johanna Flaim (daughter) Same as above</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>331X</u> DUE TO <u>Cerebral Hemorrhage</u> <u>ARTERIOSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>GRADUAL</u>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>10 HRS</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a)</b>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Nov 22 1961</u> <b>to</b> <u>Nov 23 1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>Nov 22 1961</u> , <b>and that death occurred at</b> <u>11:23 A.M.</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Leo Donovan</u>				<b>22b. DATE SIGNED</b> <u>11/23/61</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Leo Donovan</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial-transit 11-23-61</u>				<b>23b. DATE THEREOF</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Joseph's Cemetery</u>	
<b>23d. LOCATION (City, town or county) (State)</b> <u>Sheppton, Penna.</u>				<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>ROBERT A. PUMPHREY</u>			
<b>25a. REC'D BY REGISTRAR</b> <u>Bethesda, Md.</u>				<b>25b. REGISTRAR'S SIGNATURE</b> <u>NOV 30 '61</u>			

TO ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT.

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME  
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12894 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

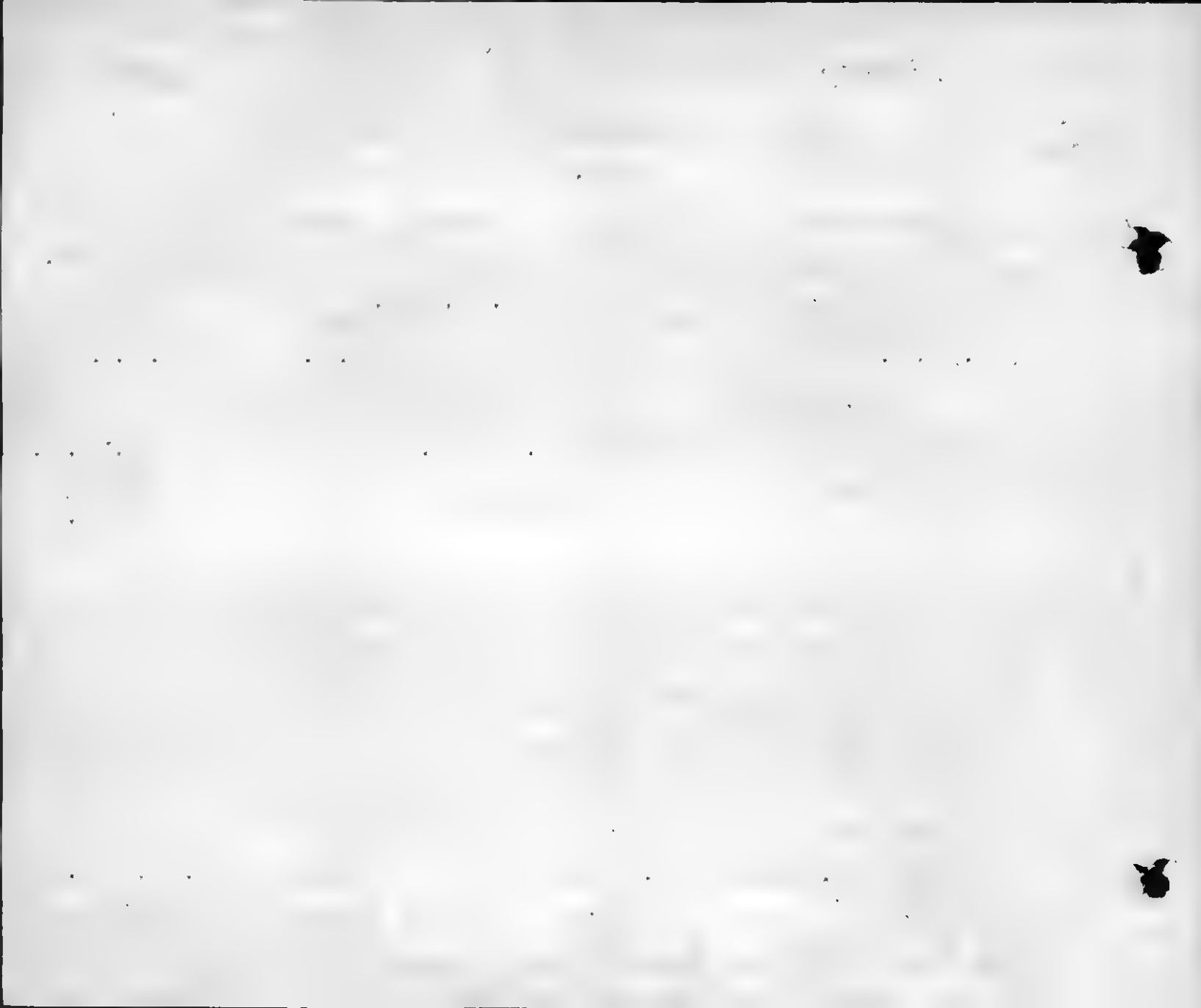
1288C

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
c. LENGTH OF STAY IN 1b <u>40 Yrs.</u>				d. STREET ADDRESS <u>7206 Maple Avenue</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7206 Maple Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>HAROLD</u> Middle <u>EUGENE</u> Last <u>SAUNDERS</u>				4. DATE OF DEATH Month <u>November</u> Day <u>12</u> , Year <u>19 61.</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 29, 1890.</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>(Ret.) U. S. Navy</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D. C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>FRED H. SAUNDERS</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>YES YEARS</u>				16. SOCIAL SECURITY NO. <u>220-32-7005</u>			
17. INFORMANT <u>MRS. GRACE G. SAUNDERS, 7206 Maple Ave. Tak. Pk. Md.</u>				Address <u>  </u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>  </u> DUE TO (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart, Md.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Examination for - 137961</u>				22b. DATE THEREOF <u>Nov. 12, 1961.</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cemetery Prince Georges Co. Maryland</u>				22d. LOCATION (City, town, or county) (State)			
23a. FUNERAL DIRECTOR <u>Arthur Walters</u>				23b. REGISTRAR'S SIGNATURE <u>Arthur Walters</u>			
23c. ADDRESS <u>254 Carroll St. Takoma Park, Md.</u>				23d. DATE NOV 14 '61			

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH  
Found dead in bed.

2



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3, 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

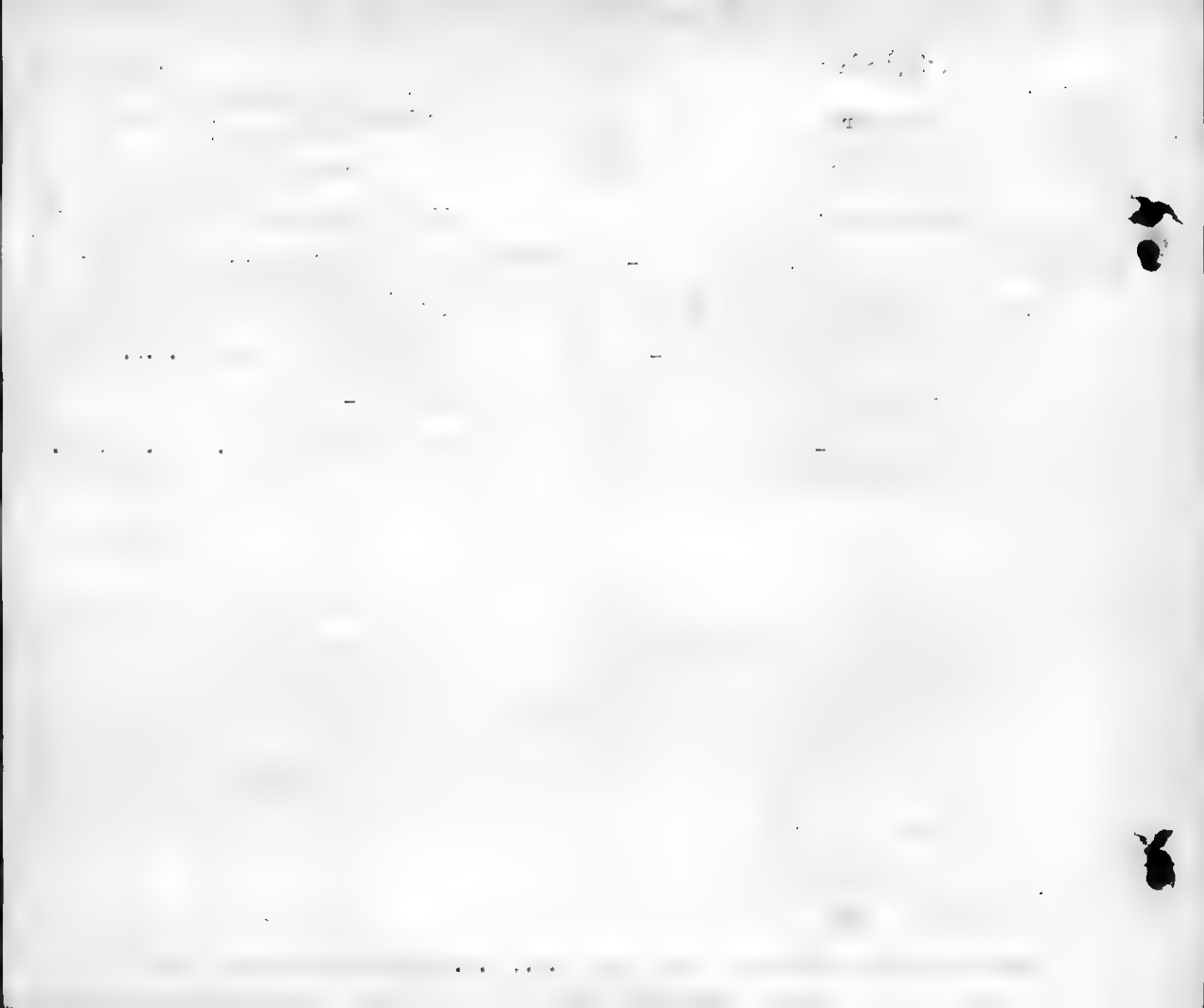
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12895

## CERTIFICATE OF DEATH

12881

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY IN 1b <b>7 Months</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>11108 Dayton Street</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> d. STREET ADDRESS <b>11108 Dayton Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>SARAH</b> First Middle Last 4. DATE OF DEATH <b>November 23, 1961</b> Month Day Year		5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>March 14, 1889</b> 9. AGE (In years last birthday) <b>72</b> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b> 11. BIRTHPLACE (County & State, or foreign country) <b>Russia</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry Spires</b>		14. MOTHER'S MAIDEN NAME <b>Ida</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b> 17. INFORMANT <b>Nora Epstein</b> Address <b>11108 Dayton St., Sil. Spg, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Insufficiency</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Sclerosis</b> DUE TO (c) <b>2 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 HR.</b>	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Old Myocardial Infarction; Renal Insufficiency</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 1</b> , 19 <b>61</b> , to <b>Nov. 23</b> , 19 <b>61</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>Nov. 22</b> , 19 <b>61</b> , and that death occurred at <b>10:30 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Samuel Dessoff</b> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>SAMUEL DESSOFF</b>		22d. ADDRESS <b>1362-18th St. N.W. Wash D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 26, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Brooklyn, New York</b>	
24 FUNERAL DIRECTOR'S SIGNATURE <b>Goldberg Funeral Home</b> ADDRESS <b>4217 9th Street N.W., D.C.</b>		25a. REC'D BY REGISTRAR <b>NOV 27 '61</b> 25b. REGISTRAR'S SIGNATURE <b>William S. Kline</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12896

12882

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Md.</u>				c. LENGTH OF STAY IN 1b <u>6 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bethesda Garden Inn</u>				d. STREET ADDRESS <u>1304 Teckman Mill</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Martin</u> Last <u>Seaman</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>18</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 25 1871</u>	
9. AGE (In years last birthday) <u>90</u>		IF UNDER 1 YEAR Months <u>9</u> Days <u>23</u>		IF UNDER 24 HRS Hours <u>4</u> Min. <u>3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of work ng life even if retired) <u>Retired Captain</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>— — —</u>			
11. BIRTHPLACE (State or foreign country) <u>New York, USA</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Jacob Seaman</u>				14. MOTHER'S MAIDEN NAME <u>Mabel Seaman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>713-09-1912</u>			
17. INFORMANT <u>1304 Teckman Mill, Bethesda, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Degenerative Myocarditis</u> DUE TO (c) <u>Coronary Sclerosis + Myocardial Heart Block</u> 7 yrs. INTERVAL BETWEEN ONSET AND DEATH <u>11/16/61</u>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>— — —</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>11/20/61</u> 19 <u>61</u> to <u>11/18/61</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>11/18/61</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Howard T. Moise</u> M.D.				22b. DATE SIGNED <u>11/18/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Howard T. Moise</u>				22d. ADDRESS <u>2010 Carroll Ave. N.W. Wash D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>11-20-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>ARLINGTON, N.J.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles F. Adams</u> ADDRESS <u>1756 Pa Ave. N.W.</u>				25a. REC'D BY REGISTRAR <u>NOV 21 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Charles E. Adams</u>	



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
12897 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12882

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if different from: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>10 Rockville</u>	
c. LENGTH OF STAY IN 1b <u>3 yrs</u>		d. STREET ADDRESS <u>1201 S. Washington St</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>201 S. Washington St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert Nichols Shaver</u>		4. DATE OF DEATH <u>Nov 29 1961</u>	
SEX <u>male</u>	6. CO. OR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>10-24-06</u>
9. AGE (In years last birthday) <u>55</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labourer</u>		11. BIRTHPLACE (State or foreign country) <u>N.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>		13. FATHER'S NAME <u>Zebulon V. Shaver</u>	
14. MOTHER'S MAIDEN NAME <u>Bertha Beck</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>yes WWII</u>	
16. SOCIAL SECURITY NO. <u>398-05-7083</u>		17. INFORMANT <u>Bertha B. Shaver</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> 795.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Aspiration of gastric contents</u> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>11-30-61</u> DATE SIGNED ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D. EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u> 22b. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>12/4/61</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u> 22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u> 23. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Maryland</u> 24a. REC'D BY REGISTRAR <u>DEC 4 '61</u> 24b. REGISTRAR'S SIGNATURE <u>C. E. Howard</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12898

CERTIFICATE OF DEATH

12884

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Takoma Park

c. LENGTH OF STAY IN 1b

two days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Washington Sanitarium & Hospital

3. NAME OF DECEASED (Type or print)

ROBERT

ARTHUR

Middle

SHAW

Last

4. DATE OF DEATH

Month

Day

Year

Nov.

23

1961

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

June 2, 1913

9. AGE (In years last birthday)

48 yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Salesman

10b. KIND OF BUSINESS OR INDUSTRY

Automobile

11. BIRTHPLACE (County & State or foreign country)

New Jersey

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Harry Shaw

14. MOTHER'S MAIDEN NAME

Katherine P. Broffitt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

577-03-8227

17. INFORMANT

1523 Live Oak Drive

Mrs. Helen K. Shaw Silver Spring, Maryland

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

531X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

Cerebral Vascular Accident

INTERVAL BETWEEN ONSET AND DEATH

3 1/2 hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

None

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m.

Month, Day, Year

20d. INJURY OCCURRED While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. [City or town]

[County]

[State]

21. I certify that (I) (this hospital) attended the deceased from Nov 22, 1961 to Nov 23, 1961, that (I) (we) last saw the deceased alive on Nov 22, 1961, and that death occurred at Nov 23, 1961, from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

Dr. John S. Rogers

M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22b. DATE SIGNED

Nov 24, 1961

22d. ADDRESS

1919 Seminary Road, Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

11/27/61

23c. NAME OF CEMETERY OR CREMATORY

Parklawn Cemetery

23d. LOCATION (City, town or county)

Montgomery County, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE

WARNER E. PUMPHREY, INC. Silver Spring, Maryland

25a. REC'D BY REGISTRAR

DATE NOV 27 '61

25b. REGISTRAR'S SIGNATURE

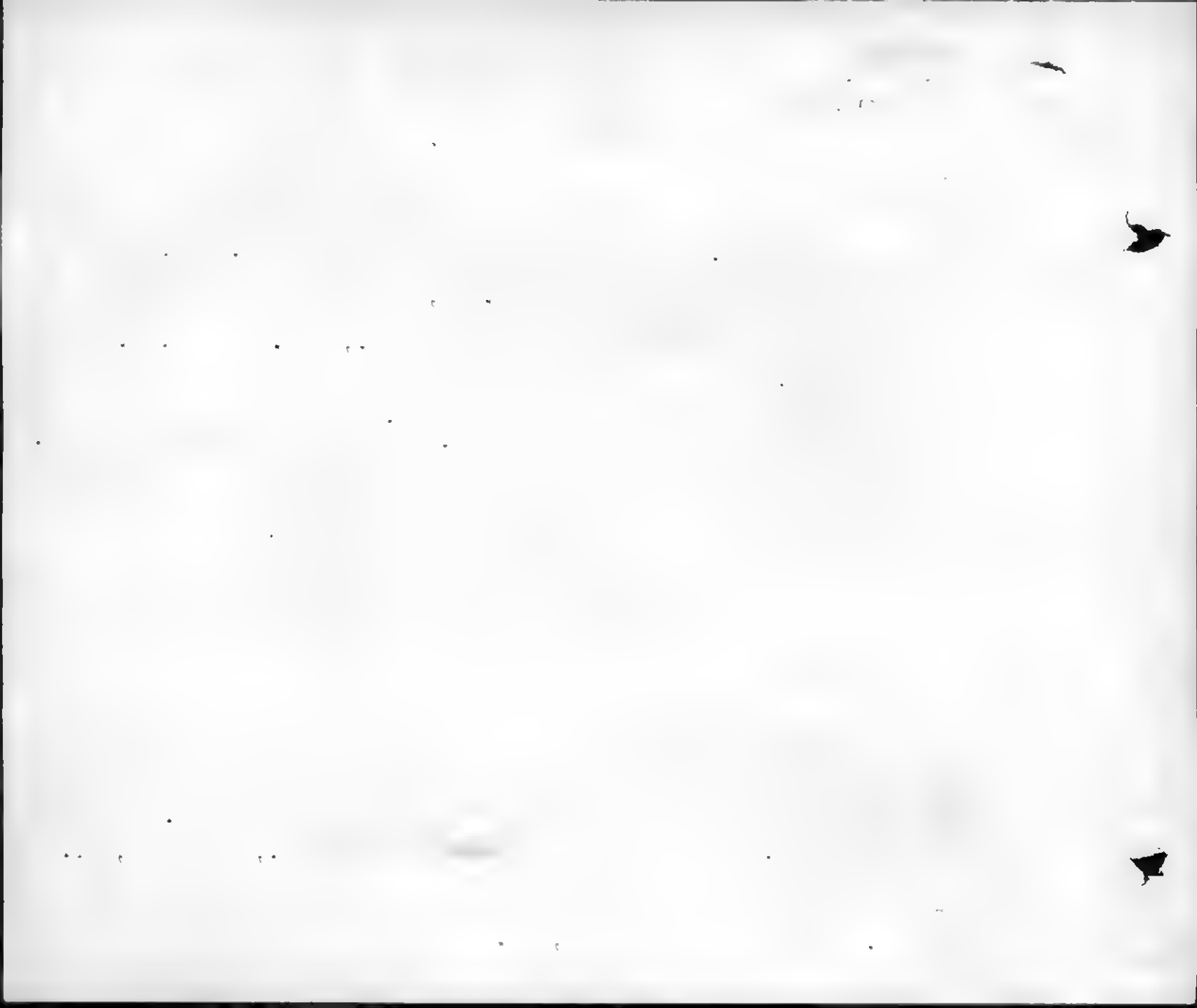
Arthur S. Kraus



12899

12885

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived) If institution, Residence before admission a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cabin John</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cabin John</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7905 Woodrow Place</b>				d. STREET ADDRESS <b>7905 Woodrow Place</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>JOSEPH M.</b>		Last <b>SHEPHERD</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>25,</b> Year <b>1961</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 10, 1872</b>	
				9. AGE (In years last birthday) <b>89</b> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Minister</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Madison Co., Ind.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>John Shepherd</b>				14. MOTHER'S MAIDEN NAME <b>Flora Heidy</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>Son.</b> <b>George J. Shepherd</b>		Address <b>Same as Item 2.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b> DUE TO (b) <b>CEREBRAL ARTERIOSCLEROSIS</b> DUE TO (c) <b>GENERAL ARTERIOSCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b> <b>10 YEARS</b> <b>10 YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>DIABETES MELLITUS</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>OCT. 15, 1954</b> to <b>NOV. 25, 1961</b> , that (I) (we) last saw the deceased alive on <b>NOV. 24, 1961</b> , and that death occurred at <b>8:30 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Robert G. Angle</b>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>NOV. 25, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>ROBERT G. ANGLE</b>				22d. ADDRESS <b>5009 Del Ray Ave., Bethesda, Md.</b>			
23a. BURIAL CREMATION REMOVAL (Specify) <b>Burial-transit 11-26-61</b>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <b>Gravell Lawn</b>		23d. LOCATION (City, town, or county) (State) <b>Fortville, Indiana</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>				ADDRESS <b>Bethesda, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 30 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>W. J. Jones</b>			



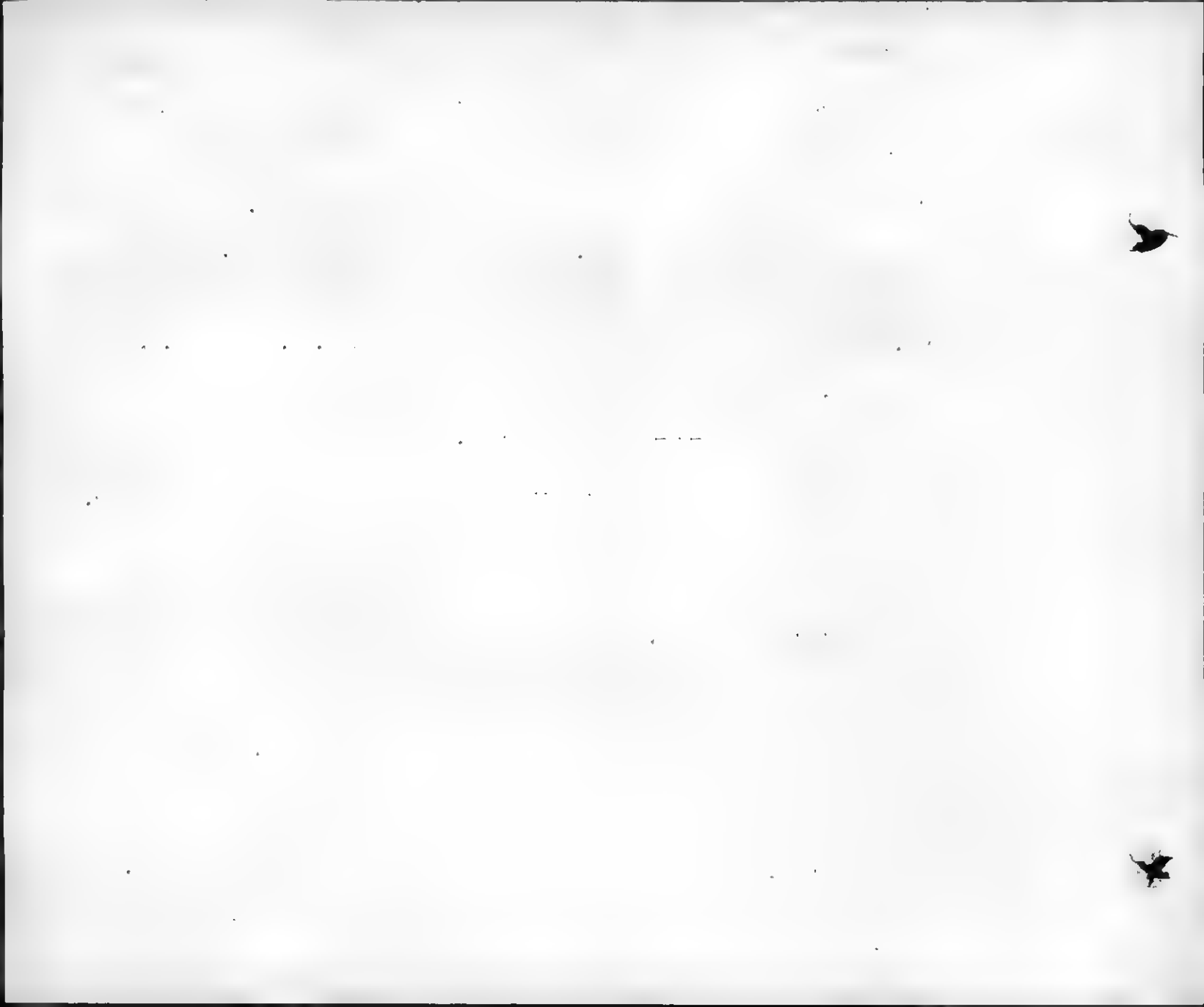
may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

12900

12386

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>14 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Harvey</b> Middle <b>J.</b> Last <b>Shipley</b>				4. DATE OF DEATH Month <b>November</b> Day <b>13</b> Year <b>1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/19/02</b>		9. AGE (In years last birthday) <b>59</b> yrs	IF UNDER 1 YEAR Months <b>59</b> Days <b>13</b> Hours <b>1</b> Min.	IF UNDER 24 HRS. Hours <b>1</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Serv-Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Emerson &amp; Orme</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph J. Shipley</b>				14. MOTHER'S MAIDEN NAME <b>Grace Hipsley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>WW II</b>		16. SOCIAL SECURITY NO. <b>578-03-4062</b>		17. INFORMANT <b>Milford A. Shipley (brother)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombosis</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>Cervical Neuritis.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 20</b> , <b>1961</b> , to <b>Nov. 13, 1961</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Robert N. Goale M.D.</b>				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Robert N. Goale</b>				22d. ADDRESS <b>4429 Bradley Lane, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>11-16-61</b>		23b. DATE THEREOF <b>11-16-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glenwood Ave</b>		23d. LOCATION (City, town, or county) (State) <b>Wash DC</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Sutermeister &amp; Son</b>				25a. REC'D BY REGISTRAR <b>DATE NOV 15 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12387

12901

<b>1. PLACE OF DEATH</b> COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WHEATON, MD.</u> c. LENGTH OF STAY IN 1b <u>1 YEAR</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WHEATON NURSING HOME</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> d. STREET ADDRESS <u>1007 North Mansion Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Elizabeth FELICITE Sholz</u>		<b>4. DATE OF DEATH</b> Month <u>11</u> Day <u>10</u> Year <u>1961</u>	
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>11-8-1871</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own Home</u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>BROOKLYN, N.Y.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A</u>	
<b>13. FATHER'S NAME</b> <u>CHARLES GIESE</u>		<b>14. MOTHER'S M.A.DEN NAME</b> <u>ANNA MARIE Schroth</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>	
<b>17. INFORMANT</b> <u>Mrs. Bernard T. Hammett</u>		<b>Address</b> <u>1007 N. Mansion Drive Silver Spring, Md.</u>	
<b>18. CAUSE OF DEATH</b> (Enter on y one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive heart failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>arteriosclerotic heart disease</u> (c) <u>generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>cerebral vascular accident</u>			
<b>19. INTERVAL BETWEEN ONSET AND DEATH</b> <u>5 yrs</u> <u>20 yrs</u> <u>20 yrs</u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>19</u> p.m.	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>home</u>	<b>20f. (City or town)</b> <u>Silver Spring</u> (County) (State)
<b>21. I certify that (1) (the hospital) attended the deceased from</b> <u>June 1953</u> <b>to</b> <u>Nov 10, 1961</u> , <b>that (1) (we) last saw the deceased alive on</b> <u>Nov 10, 1961</u> , <b>and that death occurred at</b> <u>3:40 AM</u> , <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>[Signature]</u>		<b>22b. DATE SIGNED</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>H. F. Kreuzburg</u>		<b>22d. ADDRESS</b> <u>7852 16th Ave Wash DC</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>TRANSIT-BURIAL</u>		<b>23b. DATE THEREOF</b> <u>11/11/61</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>CRYSTAL LAKE CEMETERY</u>		<b>23d. LOCATION (City, town or county)</b> <u>GARDNER, MASS.</u> (State)	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Raymond A. Ziska</u>		<b>25a. REC'D BY REGISTRAR</b> <u>Arthur S. Kraus</u>	
<b>24. ADDRESS</b> <u>8434 GEORGIA AVENUE</u>		<b>25b. REGISTRAR'S SIGNATURE</b>	
<b>24. NAME</b> <u>WARNER E. PUMPHREY, INC.</u>		<b>24. ADDRESS</b> <u>SILVER SPRING, MD.</u>	
<b>24. DATE</b> <u>NOV 14 '61</u>		<b>24. DATE</b>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



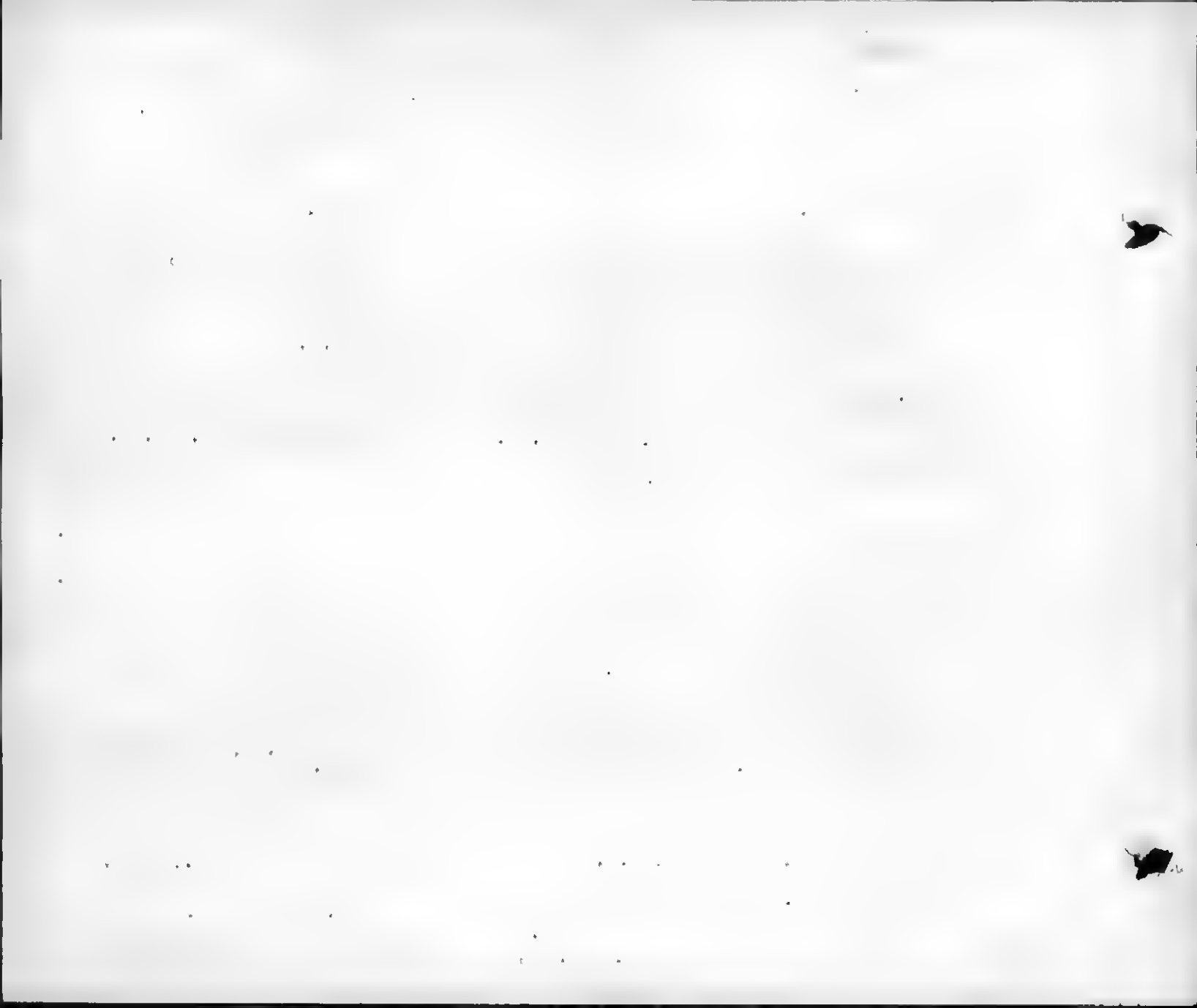
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with in 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12902

12888

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>				c. LENGTH OF STAY IN 1b <u>10 1/2</u> years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3223 Leland St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDITH G SMITH</u>				4. DATE OF DEATH Month Day Year <u>November 5, 19 61</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/14/1977</u>	
9. AGE (In years last birthday) yrs <u>84</u>		10. IF UNDER 1 YEAR Months Days Hours Min. <u>14</u> hours		11. IF UNDER 24 HRS Months Days Hours Min. <u>11</u> mos.		12. IF UNDER 24 HRS Months Days Hours Min. <u>11</u> mos.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D.C.</u>			
11. BIRTHPLACE (State or foreign country) <u>USA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>George W. Bagg</u>				14. MOTHER'S MAIDEN NAME <u>Anna Goodwin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO <u>none</u>		17. INFORMANT Address <u>F. C. Smith 3223 Leland St. Ch.Ch. Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <u>Intractable heart failure</u> <u>153.8</u> DUE TO (b). <u>generalized carcinomatosis</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c). <u>Adenocarcinoma of the colon</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c). <u>Chronic cardiovascular disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>14</u> hours <u>11</u> mos. <u>11</u> mos.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>None</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>	
20f. (City or town) (County) (State) <u>None</u>				20g. (City or town) (County) (State) <u>None</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>April 1951</u> to <u>Nov. 5, 19 61</u> that (I) (we) last saw the deceased alive on <u>Nov. 2, 19 61</u> and that death occurred at <u>7:40 a.m.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Andrew A. Marchetti</u> M.D.				22b. DATE SIGNED <u>Nov. 5, 19 61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Andrew A. Marchetti, M.D.</u>				22d. ADDRESS <u>Gerogetown University Hosp., Wash. 7, D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>11/8/1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	
23d. LOCATION (City, town, or county) (State) <u>Ft. Meade, Va.</u>				23e. LOCATION (City, town, or county) (State) <u>Ft. Meade, Va.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph B. Bowers</u>				24b. ADDRESS <u>1756 Pa. Ave. NW, Wash. DC</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 9 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>				25c. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

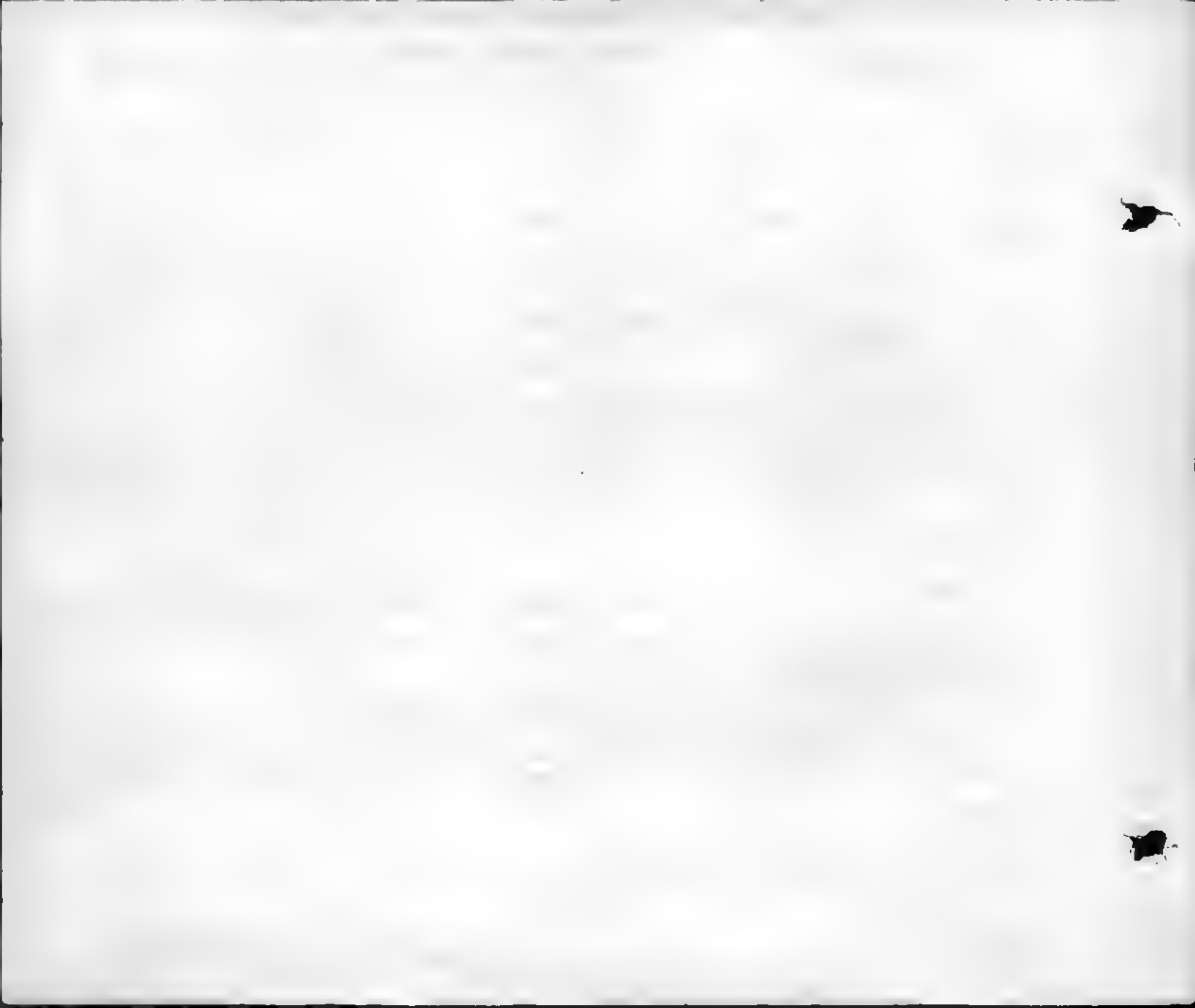
Reg. Dist. No. 12889

12903

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>5501 N. Field Rd.</b>	
3. NAME OF DECEASED (Type or print) <b>George Carlton Smith</b>		4. DATE OF DEATH <b>11 23 1961</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec 30, 1913</b>
9. AGE (In years last birthday) <b>47</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Deputy Marshall</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U S Gov</b>	
11. BIRTHPLACE (State or foreign country) <b>Wash D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George C Smith</b>		14. MOTHER'S MAIDEN NAME <b>Helen H. Perrin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Josephine A Smith</b>		Address <b>5501 N. Field Rd</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Melanotic Carcinomatosis</b> 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Carcinoma of Rectum</b> DUE TO (c) <b>Rectum</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Aug 1959</b> to <b>11/23/1961</b> , that I last saw the deceased alive on <b>11/4/61</b> , and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. T. Jones</b>		DATE SIGNED <b>11/23/61</b>	
PHYSICIAN'S NAME (Type) <b>W. T. Jones</b>		ADDRESS (Street, city or town, state) <b>8106 Maple Ridge Rd Bethesda, Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-27-61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Truitt Alewife</b>	22d. LOCATION (City, town, or county) (State) <b>Washington DC</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Deaf Leisner Home</b>		ADDRESS <b>4812 So. Ave. N.W. Wash D.C.</b>	
24a. REC'D BY REGISTRAR <b>NOV 29 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

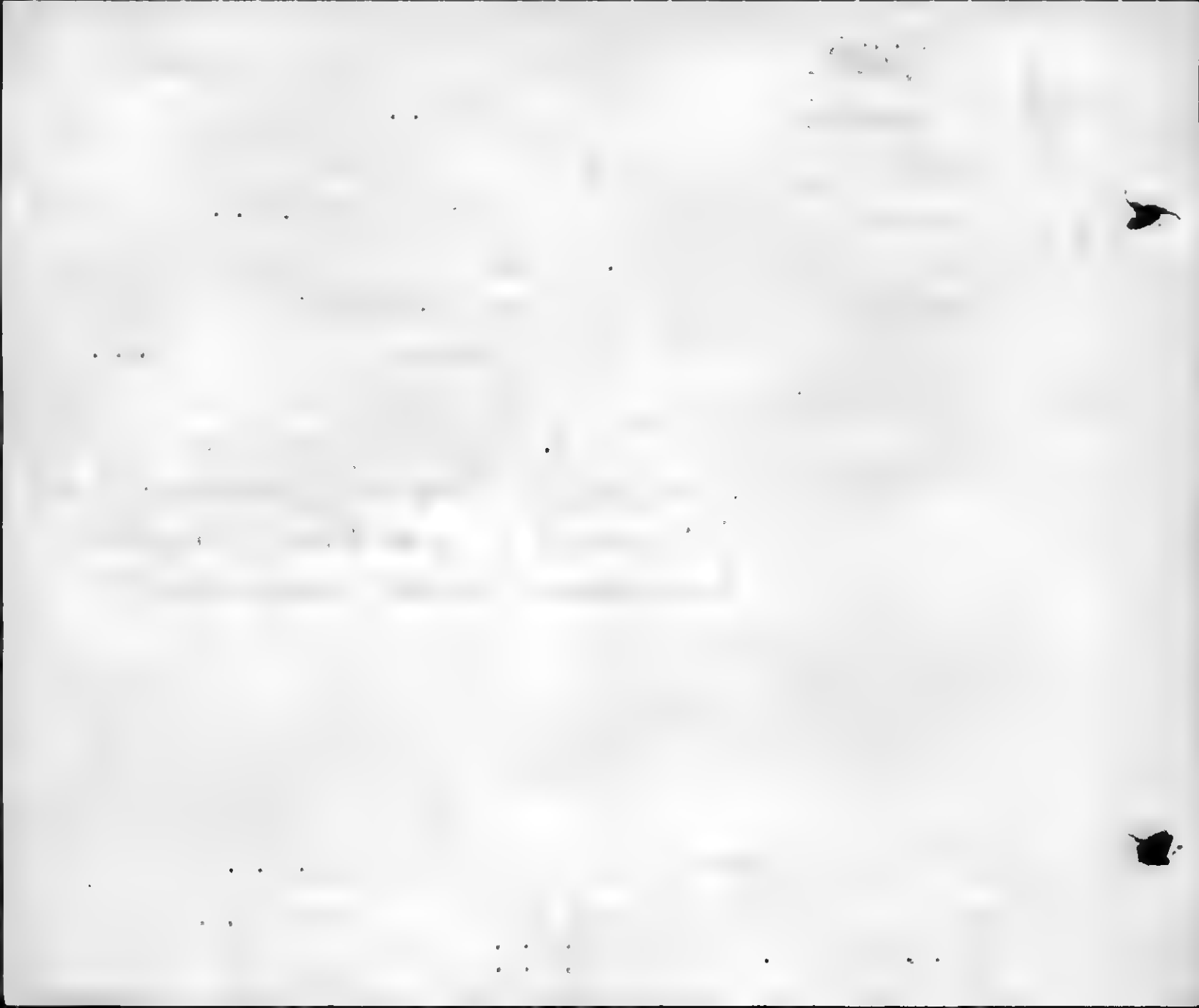
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12904

## CERTIFICATE OF DEATH

12836

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN b. <b>36 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>3278 Worthington St., N.W.</b> d. STREET ADDRESS <b>3278 Worthington St., N.W.</b>	
3. NAME OF DECEASED (Type or print) First <b>Maude</b> Middle <b>S.</b> Last <b>Smith</b>		4. DATE OF DEATH <b>November 30 1961</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 16, 1886</b>	
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>New Jersey</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Walter Hopkins</b>		14. MOTHER'S MAIDEN NAME <b>Florence Brush</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>?</b>	
17. INFORMANT <b>O. Frank Loekle (son-in-law)</b>		Address <b>same as above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Confluent Bronchopneumonia</b> DUE TO <b>Peritonitis, intestinal obstruction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Carcinoma, ileo-cecal valve</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVA. BETWEEN ONSET AND DEATH</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10-34</b> , 19 <b>61</b> , to <b>11-30</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>11-30</b> , 19 <b>61</b> , and that death occurred at <b>4:55 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Walter Atkinson</b>		22b. DATE SIGNED <b>11/30/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Walter Atkinson</b>		22d. ADDRESS <b>1835 Eye St. N.W.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		23b. DATE THEREOF <b>12/1/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Fairmount Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Newark, N.J.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>		25. REC'D BY REGISTRAR <b>DEC 4 '61</b>	
25a. ADDRESS <b>2901 14th St. N.W. Washington 9, D.C.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the Death certificate be executed within 24 hours after death. Page 1 should be filed by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

CERTIFICATE OF DEATH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12905		Item 2 - Film 627		11/8/61		12391	
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived) (If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>		c. LENGTH OF STAY IN lb <b>2 Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON/ Wash. D.C.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kensington Gardens Sanitarium</b>				d. STREET ADDRESS <b>514 Connecticut Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>STELLA</b>		First Middle Last <b>SNYDER</b>		4. DATE OF DEATH Month <b>November</b> Day <b>2</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 5, 1870</b>	
9. AGE (In years last birthday) <b>91</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Reinsmith</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Medical Record Kensington Gardens San.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.0 IMMEDIATE CAUSE (a) <b>Coronary Heart Failure (arteriosclerosis)</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>Arteriosclerosis, Heart Disease</b> DUE TO (c) <b>Senility age 90 -</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis Generalized</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>yr 5</b> <b>yr</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8/11/61</b> to <b>11/2/61</b> , that (I) (we) last saw the deceased alive on <b>11/1/61</b> , and that death occurred at <b>7:40 P.M.</b> from the causes and on the date stated above							
22a. SIGNATURE <b>SAM ALLEN</b> 22c. PHYSICIAN'S NAME (Type) <b>Sam Allen</b>				22b. DATE SIGNED <b>11/2/61</b>		22d. ADDRESS <b>Kensington, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11/7/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROCK CREEK CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>WASHINGTON, D. C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Guolieri &amp; Son, Inc. 1756 - 1st Ave NW</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 6 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the death is not reported to the hospital or attending physician, the law requires that the death certificate be executed within 24 hours after death. If the death is not reported to the hospital or attending physician, the law requires that the death certificate be executed within 24 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

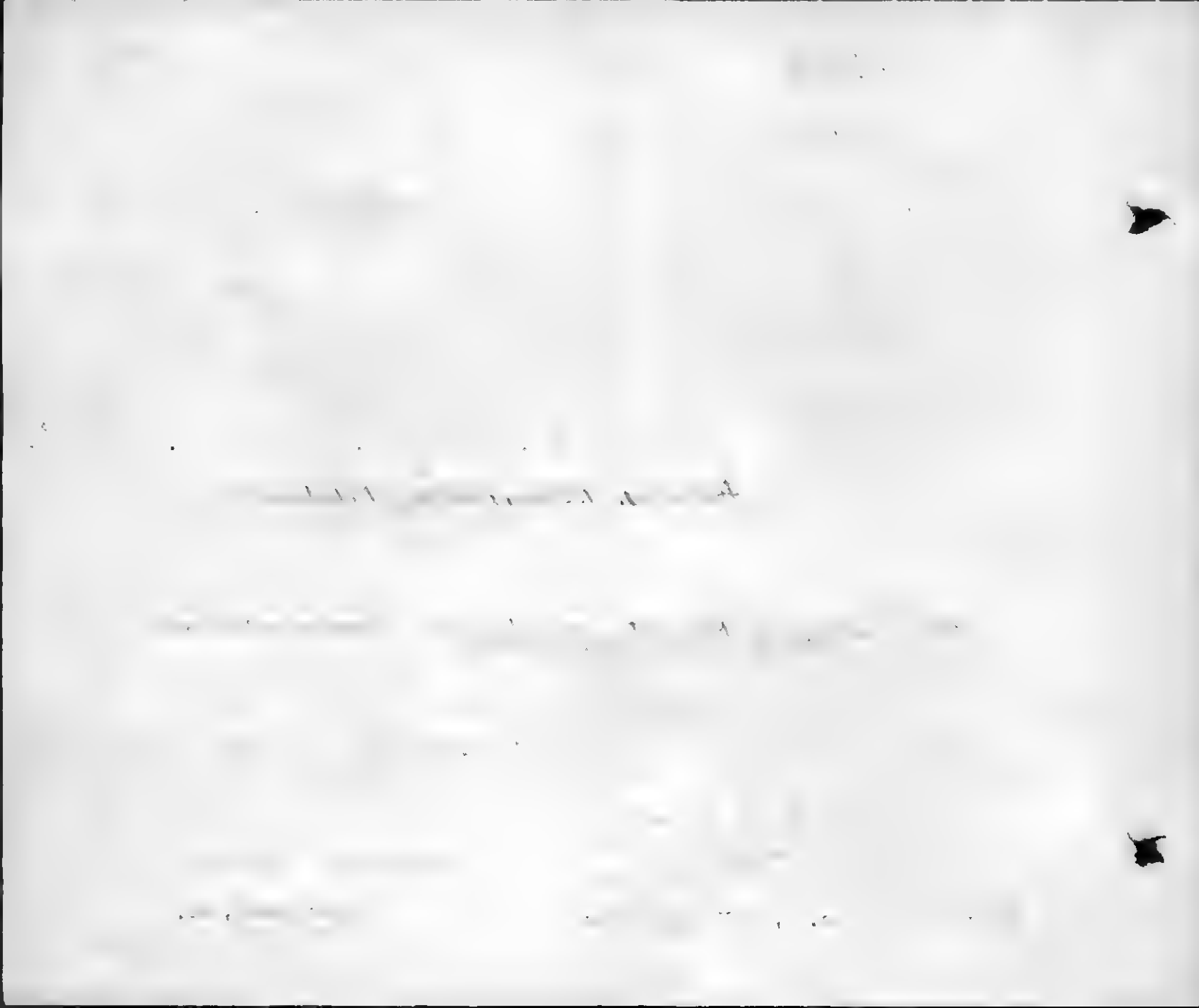
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12906

## CERTIFICATE OF DEATH

12892

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>14 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Springs</b> d. STREET ADDRESS <b>SHERATON 2717 Sheridan St.,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Anna</b> First Middle Last <b>Female</b> <b>White</b> <b>WIDOWED</b> <b>DIVORCED</b> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b> 10b. KIND OF BUSINESS OR INDUSTRY		<b>4. DATE OF DEATH</b> <b>11 30 61</b> Month Day Year <b>4/4/21</b> 9. AGE (In years last birthday) <b>40 yrs.</b> IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours M.n.	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Pennsylvania</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		<b>13. FATHER'S NAME</b> <b>Emanuel Bpjokles</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>Florence Papadakis</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b> <b>16. SOCIAL SECURITY NO.</b> <b>UNK.</b> <b>17. INFORMANT</b> <b>Mrs. Despina Seal, sister - 100 N. Oakland St.</b> Address <b>Arlington, Va.</b>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adrenal hemorrhage, bilateral</b> 274X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). <b>1-Pelvic abscess 2-Rheumatic valvular heart disease with subacute bacterial endocarditis</b> 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>19 11-30</b> Hour a.m. p.m. <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> <b>11-25, 1961</b> <b>20g. (County)</b> <b>11-30, 1961</b> <b>20h. (State)</b> <b>11-30, 1961</b>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>21. I certify that (I) (this hospital) attended the deceased from 11-25, 1961, to 11-30, 1961, that (I) (we) last saw the deceased alive on 11-30, 1961, and that death occurred at 8:30 P.M. from the causes and on the date stated above.</b>		<b>22a. SIGNATURE</b> <b>W F Marcus</b> <b>22c. PHYSICIAN'S NAME (Type)</b> <b>W F MARCUS</b> <b>22d. ADDRESS</b> <b>10620 Georgia Ave</b>	
<b>23a. BURIAL, CREMATION, 23b. DATE THEREOF</b> <b>Burial Dec. 4, 1961</b> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Fort Lincoln</b> <b>23d. LOCATION (City, town or county)</b> <b>Colmar Manor, Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DEC 4 '61</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Hume</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

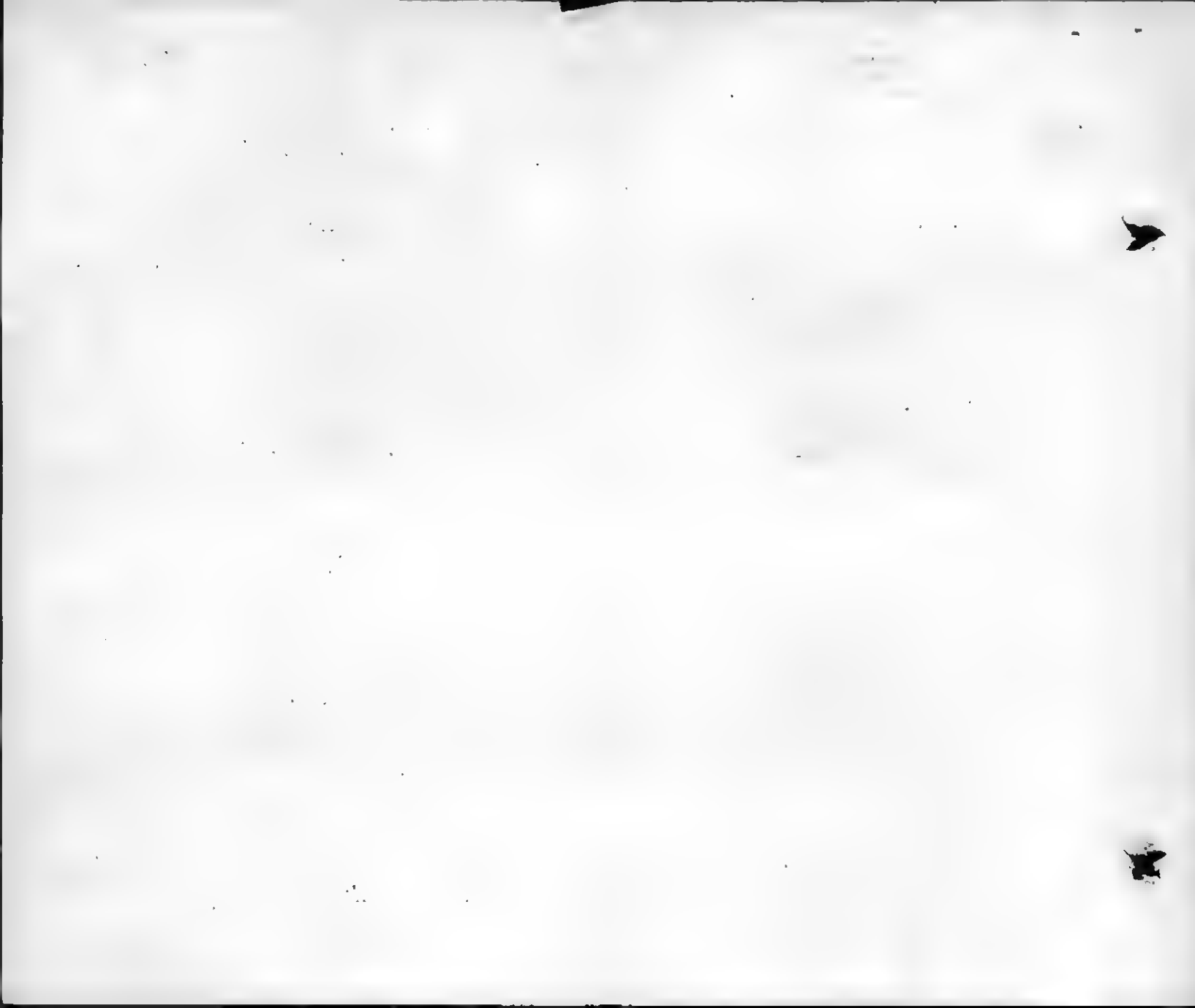
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1

12907

## CERTIFICATE OF DEATH

12893

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN 1b <u>43 days</u>		d. STREET ADDRESS <u>3201 Wisconsin Ave. NW</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Naval Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Lawrence (n) Stansell</u>		<b>4. DATE OF DEATH</b> <u>November 13, 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>May 24, 1901</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Naval Officer</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Naval Officer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Texas</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jesse P. Stansell</u>		14. MOTHER'S MAIDEN NAME <u>Mary Skinner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WWI WWII</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>WIFE: Juanita M. Stansell, Same as</u>		Address <u>2</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Cardiorespiratory cessation</u> (b) <u>Pneumonia</u> (c) <u>Pulmonary and hepatic metastases of Ca pancreas</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
<b>21. I certify that</b> <u>he</u> (this hospital) attended the deceased from <u>October 2, 1961</u> to <u>November 13, 1961</u> that <u>he</u> (we) last saw the deceased alive on <u>November 13, 1961</u> , and that death occurred at <u>9:18 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph H. Eusterman</u> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH H. EUSTERMAN LT MC USN</u>		22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Nov 16, 1961</u>		23b. DATE THEREOF <u>Nov 16, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. A. PUMPHREY</u>		25a. REC'D BY REGISTRAR <u>NOV 16 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

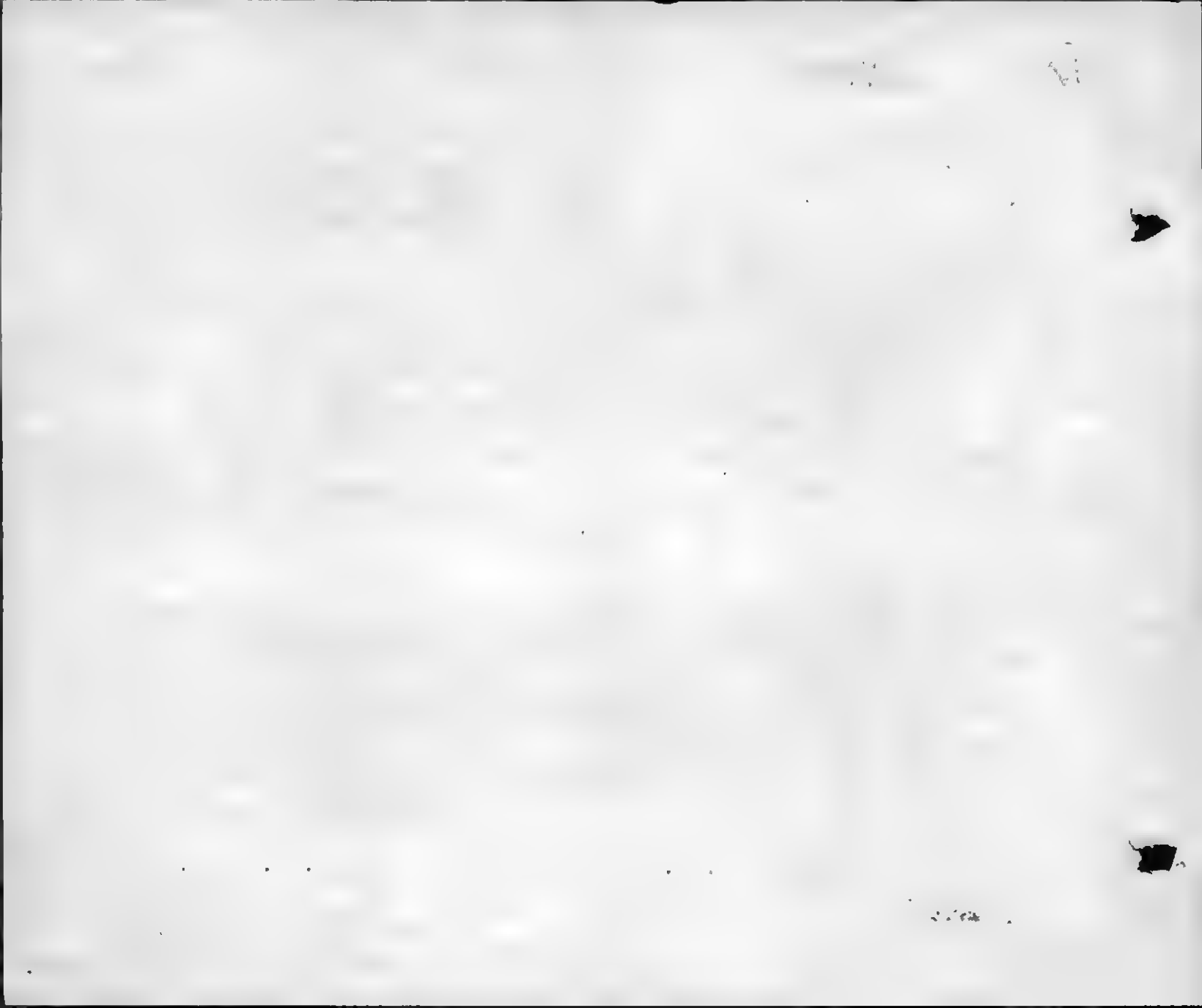
## CERTIFICATE OF DEATH

12894

12908

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>12 weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>2805 Nicholson St</u>									
<b>3. NAME OF DECEASED</b> (Type or print) <u>Florine C. Steele</u>		<b>4. DATE OF DEATH</b> Month <u>Nov.</u> Day <u>21</u> Year <u>1961</u>									
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>									
<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>July 7, 1890</u>									
<b>9. AGE</b> (In years last birthday) <u>71</u> yrs. <table border="1" style="display: inline-table; vertical-align: top;"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
IF UNDER 1 YEAR		IF UNDER 24 HRS.									
Months	Days	Hours	Min.								
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>									
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>United States of America</u>		<b>13. FATHER'S NAME</b> <u>Benjamin Cullison</u>									
<b>14. MOTHER'S MAIDEN NAME</b> <u>Evelina Gibson</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>									
<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>		<b>17. INFORMANT</b> <u>Jean Talies - Washington San. &amp; Hosp.</u>									
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE <u>1-3-8 Carcinoma of colon - metastatic to lungs and liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <table border="1" style="display: inline-table; vertical-align: top;"> <tr> <td>(a)</td> <td>(b)</td> <td>(c)</td> </tr> </table>		(a)	(b)	(c)	<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
(a)	(b)	(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u>Essential hypertension; arteriosclerosis; peripheral vascular disease; Chronic sinusitis; phlebitis; deep</u>											
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>											
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II, of item 18)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>19</u> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>									
<b>21. I certify that (I) (this hospital) attended the deceased from...</b> <u>March 1955</u> <b>to...</b> <u>11-21-61</u> <b>19...</b> <u>61</u> <b>that (I) (we) last saw the deceased alive on...</b> <u>11-20-61</u> <b>19...</b> <u>61</u> <b>and that death occurred at...</b> <u>7:30</u> <b>M.</b> <b>from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <u>Jason Geiger</u>		<b>22b. DATE SIGNED</b> <u>11-21-61</u>									
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Jason Geiger, M.D.</u>		<b>22d. ADDRESS</b> <u>1112 Spring St. S.S. Md.</u>									
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>11-24-1961</u>									
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Woodlawn Cemetery</u>		<b>23d. LOCATION (City, town or county) (State)</b> <u>Baltimore, Maryland</u>									
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>W.W. Chambers Co., Riverdale, Md.</u>		<b>25. REC'D BY REGISTRAR</b> DATE <u>NOV 24 '61</u>									
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Knox</u>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. file pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

12909 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12895

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN IL <u>11 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>x Silver Spring</u> d. STREET ADDRESS <u>40312 Lanston Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Viola</u> Middle <u>Jane</u> Last <u>Stevenson</u>		4. DATE OF DEATH Month <u>11</u> Day <u>11</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-11-70</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	9. AGE (in years last birthday) <u>91</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>James M. Lane</u>		14. MOTHER'S MAIDEN NAME <u>Nancy Dooley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Washington Sanitarium &amp; Hospital Records</u>	
17. INFORMANT <u>Washington Sanitarium &amp; Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> DUE TO <u>1904.0</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>CORONARY OCCLUSION</u> DUE TO <u>FRACTURE LEFT HIP</u> (c) <u>FRACTURE LEFT HIP</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> <u>3 DAYS</u> <u>12 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>BRONCHOPNEUMONIA, ACUTE</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>x</u>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Reported fell at home fracturing left hip</u>		
20c. TIME OF INJURY Month, Day, Year <u>9 10-31 1961</u> Hour a.m. <u>9</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Silver Spring Montg Md</u> (County) <u>Montgomery</u> (State) <u>Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Bluschan</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BLUSCHAN</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, <u>Interment</u>		22b. DATE THEREOF <u>11/12/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lebanon</u>		22d. LOCATION (City, town, or country) <u>Indiana</u> (State)	
23. FUNERAL DIRECTOR <u>F Gasch's Sons Hyattsville Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 14 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>		DATE SIGNED <u>11-11-61</u>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12910 Items 3 & 15 Film 0300 ink 11/9/61											
12896											
1. PLACE OF DEATH a. COUNTY		Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE		Virginia		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Bethesda (Rural)		c. LENGTH OF STAY IN lb		25 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Falls Church	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		U. S. Naval Hospital		d. STREET ADDRESS		1313 Stoneybrae Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		John		Middle		Stockebrand		4. DATE OF DEATH		November 3 1961	
5. SEX		Male		6. COLOR OR RACE		Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
										July 27, 1892	
										9. AGE (In years last birthday) 69 yrs.	
										10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
										School Teacher	
										10b. KIND OF BUSINESS OR INDUSTRY	
										11. BIRTHPLACE (County & State, or foreign country)	
										Kansas	
										12. CITIZEN OF WHAT COUNTRY?	
										USA	
13. FATHER'S NAME		William H. Stockebrand		14. MOTHER'S MAIDEN NAME		Augusta Bayer		Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		No		16. SOCIAL SECURITY NO.		515-09-1296		17. INFORMANT		SON: Archie P. Stockebrand, same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		1777		DUE TO		Hypostatic Pneumonia		INTERVAL BETWEEN ONSET AND DEATH	
		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO		Carcinoma of the Prostate with		2 days	
				(c)		DUE TO		multiple metastases		10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year		Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (this hospital) attended the deceased from October 10, 1961, to November 3, 1961, that (I) (we) last saw the deceased alive on November 3, 1961, and that death occurred at 3:04 AM from the causes and on the date stated above.											
22a. SIGNATURE		H. S. Irons		M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED		November 3, 1961	
22c. PHYSICIAN'S NAME (Type)		H. S. IRONS LT MC USN				22d. ADDRESS		U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		Transit		23b. DATE THEREOF		11-4-61		23c. NAME OF CEMETERY OR CREMATORY		Municipal Cemetery	
23d. LOCATION (City, town or county)								23e. LOCATION (City, town or county)		Yates Center, Kansas	
24. FUNERAL DIRECTOR'S SIGNATURE		ROBERT A. PUMPHREY		ADDRESS		Bethesda, Maryland		25a. REC'D BY REGISTRAR		DATE NOV 6 '61	
								25b. REGISTRAR'S SIGNATURE		Othmar S. Kraus	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

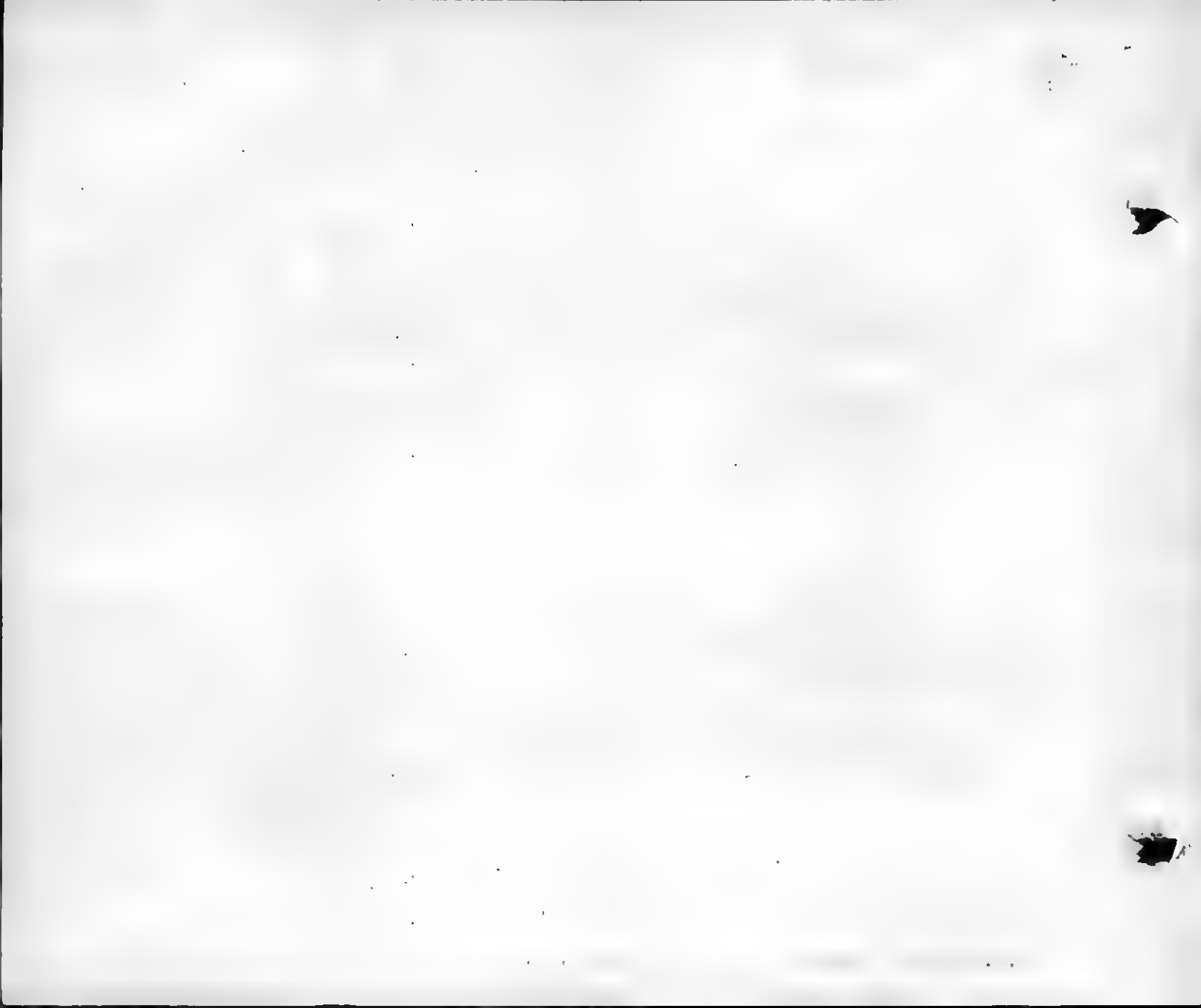
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12911

## CERTIFICATE OF DEATH

12897

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>1 hr. 50 mins.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lexington Park</b> d. STREET ADDRESS <b>56 W. Rennell</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Kevin Joe Styer</b>		4. DATE OF DEATH Month <b>November</b> Day <b>17</b> Year <b>1961</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 16, 1961</b>	
9. AGE (In years last birthday) <b>0</b> Months <b>1</b> Days <b>1</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Walter McRae Styer</b>		14. MOTHER'S MAIDEN NAME <b>Jacqueline Jo Fowler</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Hospital Records</b>		Address <b>None</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anemia</b> 770.0 DUE TO <b>Postmaternal Transfusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Postmaternal Transfusion</b> DUE TO (c) <b>Postmaternal Transfusion</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.) 20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour a.m. <b>12:50 PM</b> p.m. <b>12:50 PM</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (X) (this hospital) attended the deceased from <b>November 17, 1961</b> to <b>November 17, 1961</b> , that (I) (we) last saw the deceased alive on <b>November 17, 1961</b> , and that death occurred at <b>12:50 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Bernard H. Feldman</b> 22c. PHYSICIAN'S NAME (Type) <b>BERNARD H. FELDMAN LT MC USN</b>		22b. DATE SIGNED <b>November 17, 1961</b> 22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-24-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town or county) (State) <b>Arlington, Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers</b> ADDRESS <b>W.W. Chambers Funeral Home, Washington, D. C.</b>		25a. REC'D BY REGISTRAR <b>NOV 24 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Charles S. Haines</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

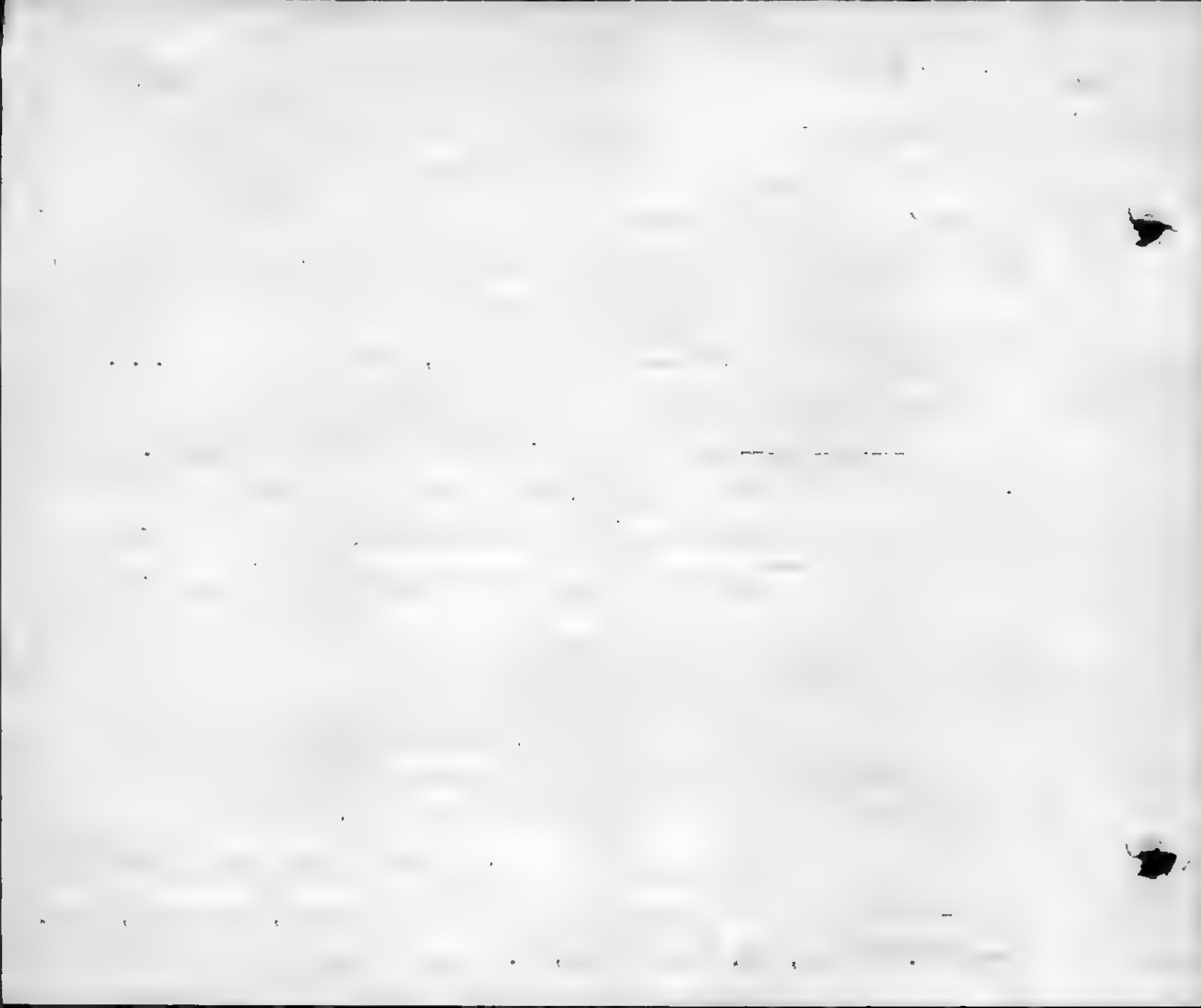
12912

## CERTIFICATE OF DEATH

12390

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHEATON</u> c. LENGTH OF STAY IN 1b _____ d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WHEATON NURSING HOME</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if not before residence before admission) a. STATE _____ b. COUNTY <u>✓</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2127 - EAST 2nd ST., 4 - 5</u> d. STREET ADDRESS <u>Long Beach, California</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>(SWEET) Agnes Ellen SWEET</u> First Middle Last f. SEX <u>F</u> g. COLOR OR RACE <u>W</u> h. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> i. DATE OF BIRTH <u>JAN 1896</u> j. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> k. AGE (In years last birthday) <u>96</u> yrs. l. IF UNDER 1 YEAR _____ m. IF UNDER 24 HRS. _____		<b>4. DATE OF DEATH</b> <u>NOV 5 1961</u> Month Day Year		<b>5. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u> <b>6. KIND OF BUSINESS OR INDUSTRY</b> <u>Own Home</u> <b>7. BIRTHPLACE</b> (County & State, or foreign country) <u>Unity, Maine</u> <b>8. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>9. FATHER'S NAME</b> <u>LUDLEY PERLEY CHARK</u> <b>10. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>11. SOCIAL SECURITY NO.</b> <u>None</u> <b>12. INFORMANT</b> <u>Mrs. Nancy Canning</u> Address <u>700 Sligo Avenue, Silver Spring, Md.</u>		<b>13. MOTHER'S MAIDEN NAME</b> <u>Lucy Ellen WARE</u> <b>14. INTERVAL BETWEEN ONSET AND DEATH</b> <u>30 DAYS</u> <b>15. GENERALIZED ARTERIOSCLEROSIS</b> <u>25 YEARS</u> <b>16. ARTERIOSCLEROTIC HEART DISEASE</b> <u>20 YEARS</u>		<b>17. PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>CEREBRO-VASCULAR ACCIDENT</u> (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
<b>18. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.) _____					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ <b>20f. (City or town)</b> _____ <b>(County)</b> _____ <b>(State)</b> _____			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>NOV 2, 1960</u> <b>to</b> <u>NOV 5, 1961</u> , <b>that (I) (we) last saw the deceased alive on</b> _____ <b>19</b> , <b>and that death occurred at</b> _____ <b>M</b> , <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Belden R. Reap</u> M.D. <b>22b. PHYSICIAN'S NAME</b> (Type or print) <u>BELDEN R. REAP, M.D.</u>		<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22d. ADDRESS</b> <u>11502 Grandview Ave., Wheaton, Md</u>		<b>22b. DATE SIGNED</b> _____			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial-Transit</u> <b>23b. DATE THEREOF</b> <u>XL/10/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Forest Lawn Memorial Park</u>		<b>23d. LOCATION</b> (City, town or county) <u>Glendale, Los Angeles, Calif.</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Raymond A Ziska</u> Address <u>8434 Georgia Avenue, Silver Spring, Md.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>DATE NOV 7 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>William S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



12913

## CERTIFICATE OF DEATH

Reg. Dist. No. 12899

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. LENGTH OF STAY IN 1b <u>1 week</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Belmont Nursing Home</u>			e. STREET ADDRESS <u>17514 Yarker Ave</u>		
3. NAME OF DECEASED (Type or print) a. First <u>Annie</u> b. Middle <u>R.</u> c. Last <u>Tennyson</u>			4. DATE OF DEATH Month <u>11</u> Day <u>19</u> Year <u>1961</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-7-1897</u>		9. AGE (In years last birthday) <u>64</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Dist. of Columbia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>William F. Howard</u>		
14. MOTHER'S MAIDEN NAME <u>De Ment</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>NONE</u>			17. INFORMANT <u>Mrs. Mac Donald</u> Address <u>Belmont Nur. Home</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebra thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>2 1/2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>11/11/61</u> 19 <u>61</u> to <u>11/19/61</u> 19 <u>61</u> , that I last saw the deceased alive on <u>11/11/61</u> 19 <u>61</u> , and that death occurred at <u>2:30 P</u> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Donald Nelson</u>		ADDRESS (Street, city or town, state) <u>10620 Georgia Ave S. Silver Spring, Md.</u> DATE SIGNED <u>11/19/61</u>			
PHYSICIAN'S NAME (Type) <u>Donald Nelson</u>		ADDRESS <u>10620 Georgia Ave., Silver Spring, Md.</u>			
22a. BURIAL, CREMATION, OR OTHER DISPOSITION <u>BURIAL</u>	22b. DATE THEREOF <u>Nov. 22, 1961</u>	22c. NAME OF CEMETERY OR OTHER DISPOSITION <u>Mount Olivet Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHAMBERS CO.</u>		ADDRESS <u>8655 Georgia Ave., S.S., Md.</u>	24a. REC'D BY REGISTRAR <u>NOV 21 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	



1  
FOR STATE  
HEALTH DEPT.

TO DEP. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
FURNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12914 12300

1. PLACE OF DEATH  
a. COUNTY Montgomery b. CITY OR TOWN Bethesda c. LENGTH OF STAY IN b. 19 days  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban Hosp.

2. USUAL RESIDENCE (Where deceased lived, if not in hospital, residence before admission)  
a. STATE Md. b. COUNTY Mont. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cherry Chase 51 Md  
d. STREET ADDRESS 7107 Fulton Street e. IS RESIDENCE ON A FARM? ☒ YES ☐ NO

3. NAME OF DECEASED (Type or print) Grace Winter Thompson 4. DATE OF DEATH Nov 14 1961

5. SEX F 6. COLOR OR RACE W 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 8. DATE OF BIRTH Oct 2, 1899 9. AGE (In years last birthday) 62 yrs. 10. AGE (In years last birthday) 62 yrs. 11. BIRTHPLACE (State or foreign country) New Berlin Pa 12. CITIZEN OF WHAT COUNTRY? U.S.A.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife 10b. KIND OF BUSINESS OR INDUSTRY — 11. BIRTHPLACE (State or foreign country) New Berlin Pa 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William P. Winter 14. MOTHER'S MAIDEN NAME Elizabeth James

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — 16. SOCIAL SECURITY NO. — 17. INFORMANT Ruth Cameron Address State College Pa

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Myocardial Insufficiency  
9180 DUE TO (b) Toxic Myocarditis  
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) 3rd Degree Burns - 30-40% Body Surface  
DUE TO (c) 3rd Degree Burns - 30-40% Body Surface  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).  
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  
Woman caught fire from gas stove at home  
20c. TIME OF INJURY Month, Day, Year 2:30 p.m. 10-24-1961 20d. INJURY OCCURRED While at work ☐ Not While at work ☒ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home 20f. (City or town) Cherry Chase Montg. Md (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Frank J. Broscham M.D. CHIEF MEDICAL EXAMINER ☐  
EXAMINER'S NAME (Type) FRANK J. Broscham ASS. STANT MEDICAL EXAMINER ☐ DATE SIGNED 11-15-61  
DEPUTY MEDICAL EXAMINER ☒ Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 22b. DATE THEREOF 11/16/61 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory 22d. LOCATION (City, town, or country) Suitland, Maryland (State)

23. FUNERAL DIRECTOR Robert A. Pumphrey, Bethesda, Maryland 24a. REC'D BY REGISTRAR NOV 17 1961 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

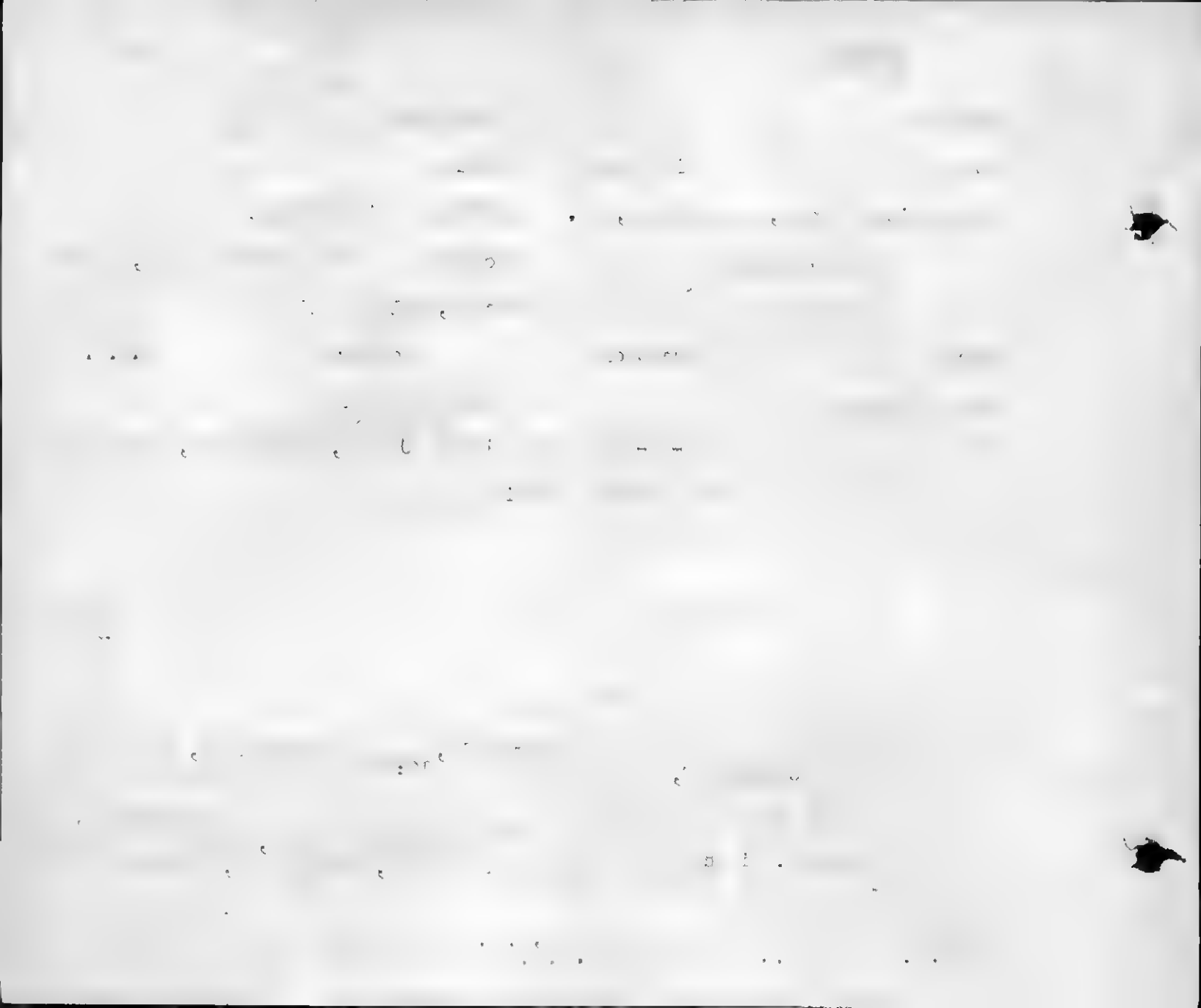
## CERTIFICATE OF DEATH

12915

12901

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside of corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>105 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Washington</b> b. COUNTY <b>Yakima</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>106 North Fifth Avenue</b> d. STREET ADDRESS <b>84x3</b>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Juanita Beth Thompson</b>		<b>4. DATE OF DEATH</b> Month <b>November</b> Day <b>27</b> Year <b>1961</b>	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>March 9, 1914</b>
<b>9. AGE</b> (In years last birthday) <b>47 yrs.</b>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Teacher</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Montana</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Elias Ruegamer</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Annetta Vaupel</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>516-26-6531</b>	
<b>17. INFORMANT</b> <b>The Medical Record</b>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adrenocortical Carcinoma</b> 1950 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <b>1950</b> DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>20. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>	
<b>20c. INJURY OCCURRED</b> While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		<b>20d. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20e. (City or town)</b> <b>August 14, 1961</b>		<b>20f. (County)</b> <b>November 27, 1961</b>	
<b>20g. (State)</b> <b>12:05AM</b>		<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>August 14, 1961</b> to <b>November 27, 1961</b> that <b>he</b> (we) last saw the deceased alive on <b>November 27, 1961</b> , and that death occurred <b>on</b> <b>November 27, 1961</b> , from the causes and on the date stated above.	
<b>22a. SIGNATURE</b> <b>M. A. Kirshner</b>		<b>22b. DATE SIGNED</b> <b>November 27, 1961</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Marvin A. Kirshner</b>		<b>22d. ADDRESS</b> <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>	
<b>23a. BURIAL - CREMATION - REMOVAL</b> (Specify) <b>removal</b>		<b>23b. DATE THEREOF</b> <b>11/28/61</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Billings, Montana</b>		<b>23d. LOCATION</b> (City, town or county) (State)	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>The S.H.Hines Co., 2901 14th St. N.W.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>NOV 29 '61</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Hines</b>			

VR A15 (4)  
15M 9/60



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12916

## CERTIFICATE OF DEATH

12902

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Res. date before admission) a. STATE <b>D.C.</b> b. COUNTY <b>--</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>11901 Georgia Avenue Wheaton Nursing Home</b>		d. STREET ADDRESS <b>1665 Harvard St., N.W.</b>	
3. NAME OF DECEASED (Type or print) <b>Charles</b>		4. DATE OF DEATH <b>Nov 16 1961</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/8/1869</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired --</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Chiropractor</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Trazzare</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Sears</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>579-38-5425</b>	
17. INFORMANT <b>Mrs. Ruth Wright</b>		Address <b>11906 Colin Road Silver Spring, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. <b>420.0</b> IMMEDIATE CAUSE (a) <b>Acute Coagulative Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>2 days</b> <b>year?</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (i) (this hospital) attended the deceased from <b>Sept 15, 1959</b> to <b>Nov 16, 1961</b> , that (i) (was) last saw the deceased alive on <b>Nov 15, 1961</b> , and that death occurred at <b>4 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Neil P. Campbell</b>		22b. DATE SIGNED <b>11/16/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Neil P. Campbell</b>		22d. ADDRESS <b>3060-16th St</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/18/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Congressional Cemetery Washington, D.C.</b>	
23d. LOCATION (City, town or county) (State)		23e. REC'D BY REGISTRAR <b>DATE NOV 17 '61</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

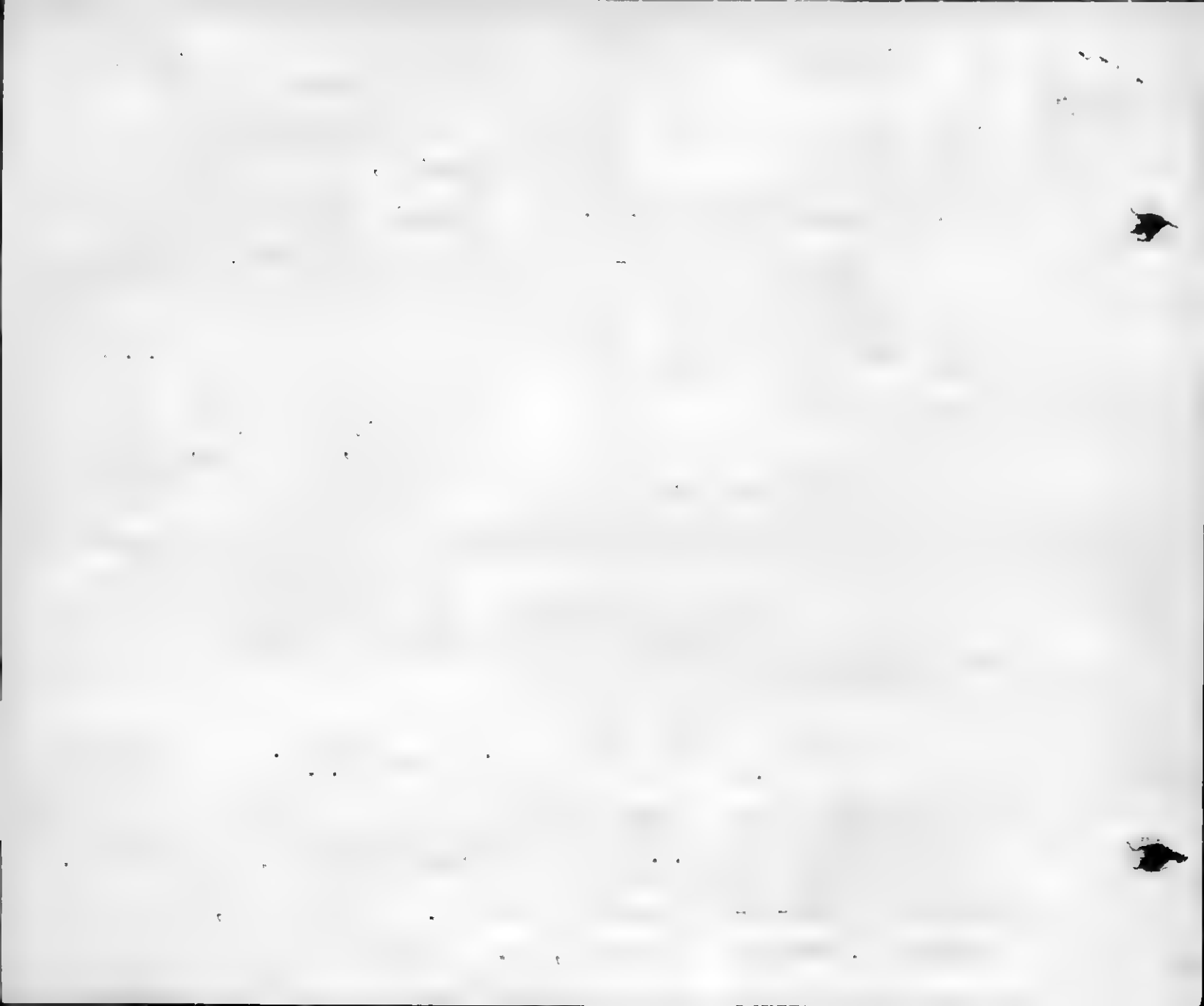
12917

12903

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN <u>6 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Alabama</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntsville,</u> d. STREET ADDRESS <u>2315 Meridan Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Reba</u> First _____ Middle _____ Last <u>Treece</u>				<b>4. DATE OF DEATH</b> Month <u>November</u> Day <u>22</u> Year <u>19 61</u>			
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <u>24 June 1928</u>		<b>9. AGE</b> (In years last birthday) <u>33</u> yrs.                 IF UNDER 1 YEAR: Months _____ Days _____                 IF UNDER 24 HRS.: Hours _____ Min. _____		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None (Housewife)</u>			
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Alabama</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>John Doss</u>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>Ginney Yancy</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>			
<b>17. INFORMANT</b> <u>The Medical Record,</u> <u>The Clinical Center, Bethesda 14, Maryland</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Meningitis</u> (b) <u>Disseminated Blastomycosis</u> (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>1 Week</u> <u>Months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>					
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____		<b>20c. TIME OF INJURY</b> Month, Day, Year _____ Hour a.m. _____ p.m. <u>19</u>					
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ (City or town) _____ (County) _____ (State) _____					
<b>21. I certify that (X) (this hospital) attended the deceased from <u>Nov. 16, 1961</u> to <u>Nov. 22, 1961</u>, that (X) (we) last saw the deceased alive on <u>Nov. 22, 1961</u>, and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>John Bennett</u> M.D.		<b>22b. ADDRESS</b> <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>		<b>22c. DATE SIGNED</b> <u>11-22-61</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial-transit 11-23-61</u>		<b>23b. DATE THEREOF</b> _____		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Greens Chapel Cem.</u>			
<b>23d. LOCATION</b> (City, town or county) <u>Scottsboro, Alabama</u> (State) _____		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>ROBERT A. PUMPHREY</u> ADDRESS <u>Bethesda, Md.</u>					
<b>25a. REC'D BY REGISTRAR</b> DATE <u>NOV 30 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>					



TO HO<sup>1</sup> OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12918

12901

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> <b>22 days</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. NAVAL HOSPITAL</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>VA.</b> b. COUNTY <b>STAFFORD (Rural)</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>STAFFORD (Rural)</b> d. STREET ADDRESS <b>RT #1 BOX 285</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>LOUISE HELEN VEAZEY</b> First Middle Last <b>4. DATE OF DEATH</b> <b>November 15 1961</b> Month Day Year		<b>5. SEX</b> <b>Female</b> <b>6. COLOR OR RACE</b> <b>Caucasian</b> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>November 18, 1928 32</b> last birthday Months Days Hours Min. <b>9. AGE</b> (In years if UNDER 1 YEAR, if UNDER 24 HRS. last birthday)	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>-----</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Louisiana</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		<b>13. FATHER'S NAME</b> <b>LIONEL TRAHAN</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>EDDAY LANGLINIS</b> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> <b>HUSBAND: Lynn J. Veazey, Same as #2</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Advanced pulmonary metastases</b> <b>170</b> DUE TO <b>carcinoma of the breast</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20c. TIME OF INJURY</b> Month, Day, Year <b>20d. INJURY OCCURRED</b> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State) Hour a.m. p.m. <b>19</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
<b>21. I certify that</b> <b>X</b> (this hospital) attended the deceased from <b>October 24 1961</b> to <b>November 15 61</b> at <b>X</b> (we) last saw the deceased alive on <b>November 15 1961</b> and that death occurred at <b>8:15 pm</b> on the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>F.M. SHEPARD LT MC USN</b> <b>22c. PHYSICIAN'S NAME</b> (Type) <b>F.M. SHEPARD LT MC USN</b>		<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/> <b>22b. DATE SIGNED</b> <b>16 November 1961</b> <b>22d. ADDRESS</b> <b>U.S. Naval Hospital, Bethesda, Md.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b> <b>23b. DATE THEREOF</b> <b>11-17-61</b> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>ABBESVILLE</b> <b>23d. LOCATION</b> (City, town or county) <b>ABBESVILLE, LOUISIANA</b> (State)		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>W. MOONSIN AVE. BETHESDA, MARYLAND</b> <b>25a. REC'D BY REGISTRAR</b> <b>DATE NOV 21 '61</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles S. Kraus</b>	



1  
FOR STATE  
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

MEDICAL CERTIFICATION

**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**12919 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

12906

1. PLACE OF DEATH  
a. COUNTY Montgomery MARYLAND  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park  
c. LENGTH OF STAY IN 1b 3 hrs.  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanit Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
a. STATE Md. b. COUNTY Montgomery  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring  
d. STREET ADDRESS 1312 Dennis Ave.

3. NAME OF DECEASED (Type or print) First Middle Last  
Mattie Elvora Wagner

4. DATE OF DEATH Month Day Year  
11 - 26 - 1961

5. SEX F 6. COLOR OR RACE W 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH 1-31-88 9. AGE (in years last birthday) 73 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Va 11. BIRTHPLACE (State or foreign country) U.S.A. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Odie Wagner 14. MOTHER'S MAIDEN NAME Gillie Barber

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. Washington Sanitarium & Hospital Records 17. INFORMANT Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Cerebral Vascular Accident  
331X DUE TO  
Conditions, if any, which gave rise to immediate cause (b) hypertension  
(a), stating the underlying cause last. DUE TO (c)  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: Previous CVA in July 1961

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 31 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town, (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 11-26-61

ACTUAL SIGNATURE Frank J. Broschelt EXAMINER'S NAME (Type) FRANK J. BROSCHELT Address (Street, city, town, or county) Waynesboro, Va

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF 11-29-61 22c. NAME OF CEMETERY OR CREMATORY River View Cemetery 22d. LOCATION (City, town, or country) (State) Waynesboro, Va

23. FUNERAL DIRECTOR C. M. Grand ADDRESS 1000 N. Arlington Ave. Arlington, Va 24. REC'D BY REGISTRAR NOV 28 '61 24b. REGISTRAR'S SIGNATURE Calvin L. France



TO HOSPITAL: The attending physician: The form requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Page 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12920

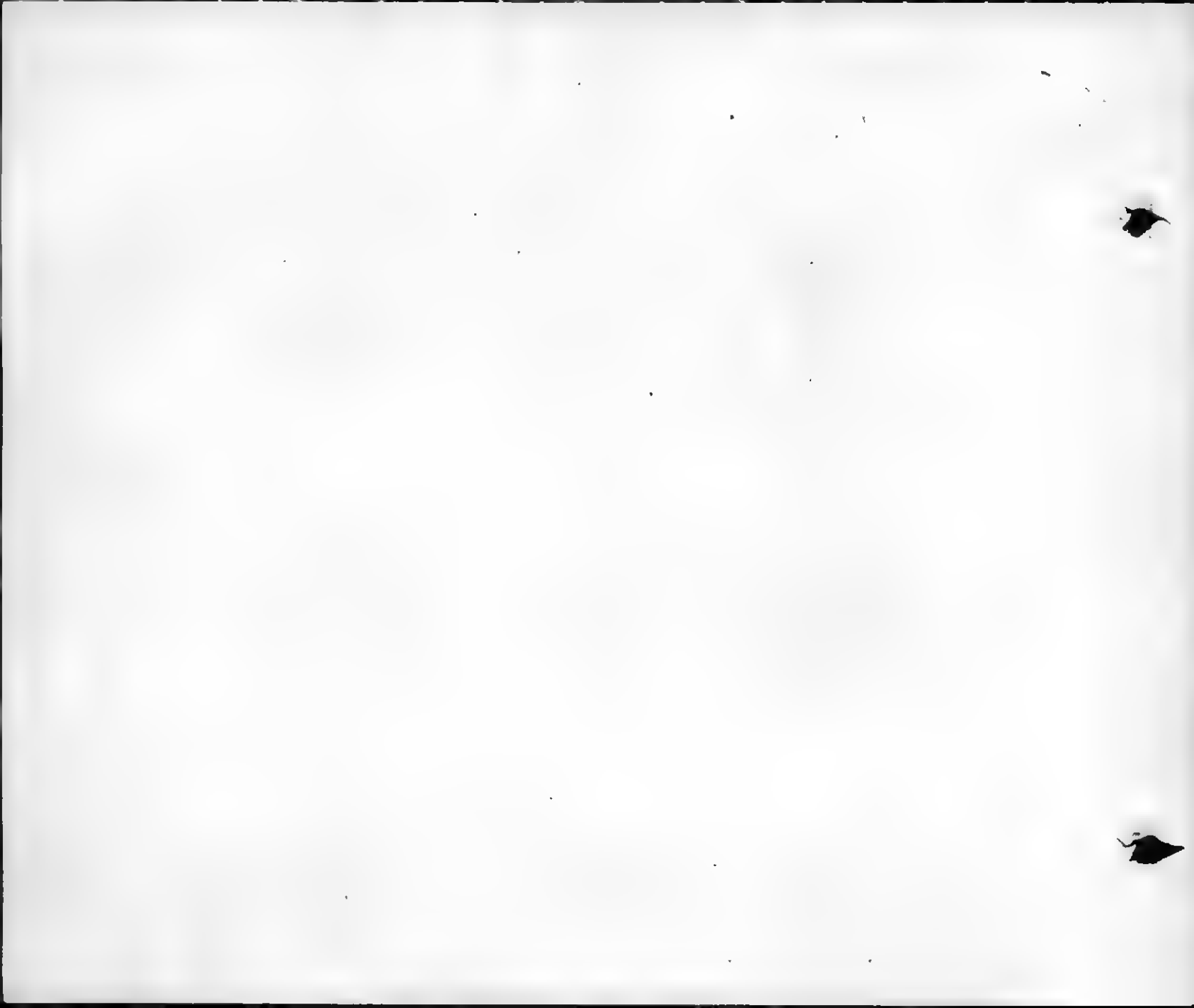
12907

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban Hospital</i>				d. STREET ADDRESS <i>10425 Darnstown Rd 1</i>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <i>Mercy</i> Middle <i>B.</i> Last <i>Ward</i>				4. DATE OF DEATH Month <i>November</i> Day <i>5</i> Year <i>1961</i>			
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>10-8-92</i>	
9. AGE (In years lost birthday) <i>69</i> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>homemaker</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>Rockville - MARYLAND</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
13. FATHER'S NAME <i>Ignatius Beall</i>				14. MOTHER'S MAIDEN NAME <i>ELIZ. FRANCES GARRETT</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>—</i>			
17. INFORMANT (Niece) <i>ELIZ. B. BANKS</i>				18. ADDRESS <i>10513 DARNSTOWN RD ROCKVILLE</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>coronary occlusion</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>arteriosclerotic cardiovascular disease</i> years DUE TO (c) <i>—</i>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>essential hypertension</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>July</i> 19 <i>55</i> to <i>Nov. 5</i> 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>Nov 4</i> 19 <i>61</i> , and that death occurred at <i>3:45</i> AM, from the causes and on the date stated above.							
22a. SIGNATURE <i>Stephen C. Cromwell</i> M.D.				22b. DATE SIGNED <i>11-5-61</i>			
22c. PHYSICIAN'S NAME (Type) <i>Stephen C. Cromwell</i>				22d. ADDRESS <i>615 W. Montgomery Ave Rockville, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11/8/61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rockville Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Rockville, Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey, Bethesda, Maryland</i>				25a. REC'D BY REGISTRAR <i>NOV 8 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

(M)

(74)

(I)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

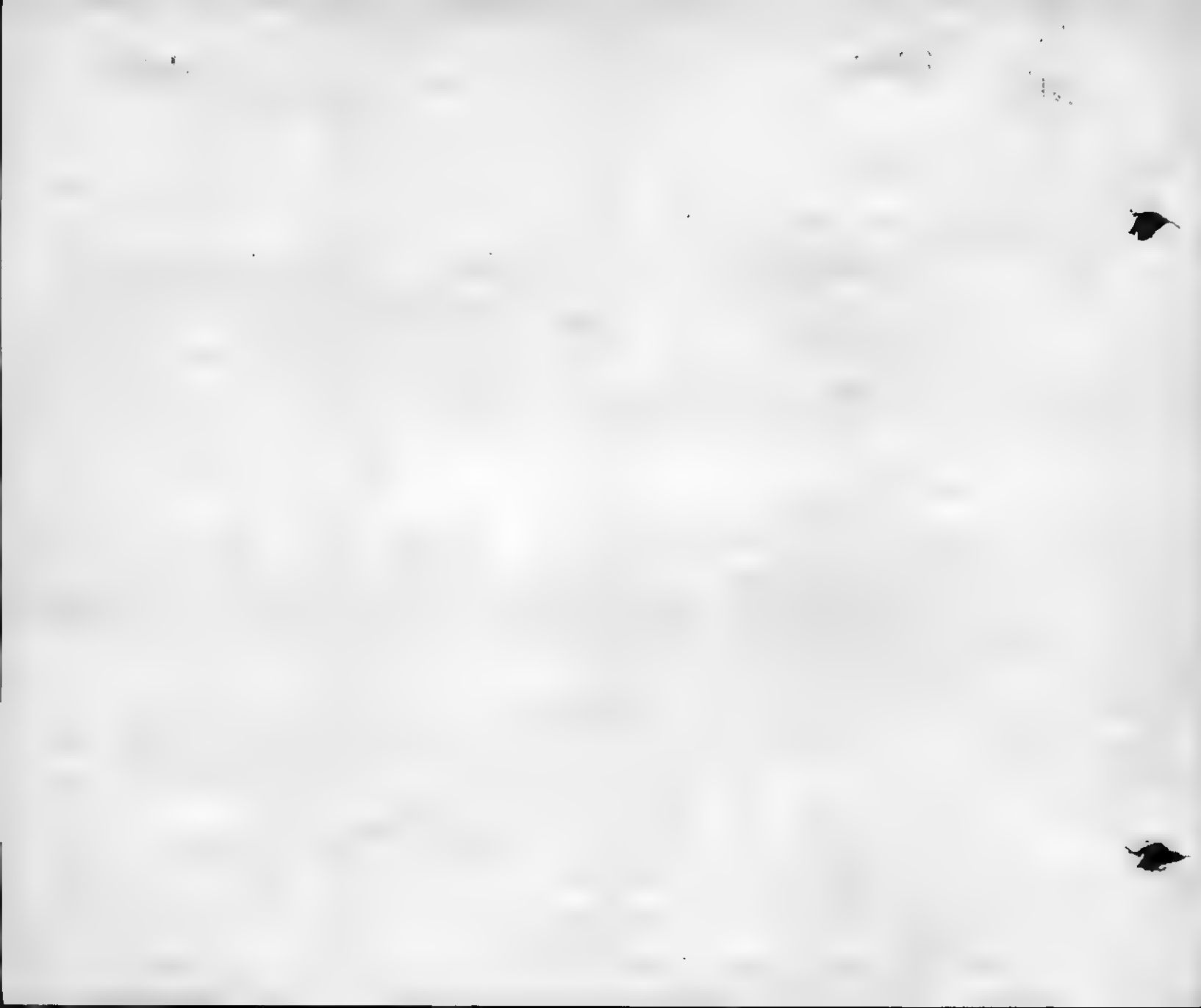
(M)

7

1

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Res. dence before admis on)			
a. COUNTY				a. STATE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				b. COUNTY			
c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospita, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
5. SEX				6. DATE OF BIRTH			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. AGE (In years last birthday)			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (County & State, or foreign country)			
10b. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT				18. INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5705 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) fractured hip 10/17/61 - hip nailed 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20d. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 10/26/61 to 11/14/61, that (I) (we) last saw the deceased alive on 11/14/61, and that death occurred at 10:45 PM, from the causes and on the date stated above.				22a. SIGNATURE J. Blaine Harrell M.D.			
22b. PHYSICIAN'S NAME (Type) J. Blaine Harrell				22c. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION 11-18-1961				23b. DATE THEREOF			
23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY				23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR'S SIGNATURE J. Lawrence Law Inc. Wash D.C.				25a. REC'D BY REGISTRAR			
25b. REGISTRAR'S SIGNATURE				25c. DATE NOV 17 '61			



## CERTIFICATE OF DEATH

Reg. Dist. No. 12909

12922

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>1033 Welsh Drive</b>				d. STREET ADDRESS <b>1033 Welsh Drive</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>NORMA</b> Middle <b>A.</b> Last <b>WHITFIELD</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>27</b> Year <b>1961</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Aug 18, 1909</b>		9. AGE (In years last birthday) <b>52 yrs</b>	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Michigan</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Axel Whitfield</b>				14. MOTHER'S MAIDEN NAME <b>Inga Strom</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>443-40-6339</b>		17. INFORMANT <b>Gary H. Whitfield-Item# 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> <b>175.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cachexia</b> (c) <b>Metastatic Cystadenocarcinoma of the Ovary</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Approx 2 1/2 yrs</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>July</b> , 19 <b>55</b> , to <b>Nov 27, 1961</b> , that I last saw the deceased alive on <b>Nov 26, 1961</b> , and that death occurred at <b>8 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Richard J. Meyer MD</b>		M.D. <b>4731 MASS. AVE. N.W. WASH 16, D.C.</b>					
PHYSICIAN'S NAME (Type) <b>RICHARD J. MEYER MD</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit</b>	22b. DATE THEREOF <b>11/27/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Perry Mount Park</b>		22d. LOCATION (City, town, or county) <b>Pontiac, Michigan</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ryson Wheeler</b> Funeral Home-1331 E. Montg. Ave. Rockville, Maryland				24a. REC'D BY REGISTRAR <b>DATE NOV 29 '61</b>		24b. REGISTRAR'S SIGNATURE <b>C. H. &amp; Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12923

# CERTIFICATE OF DEATH

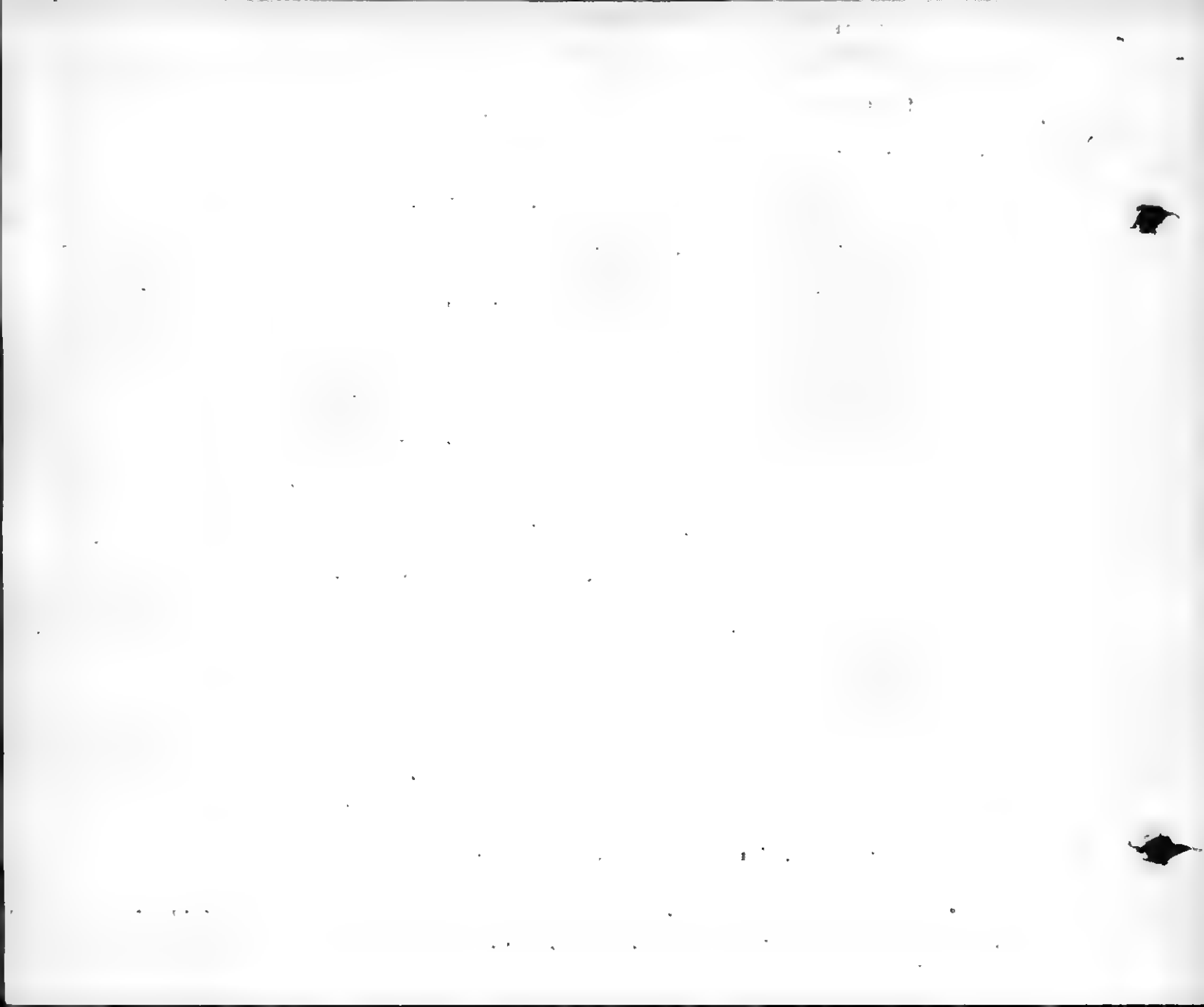
Reg. Dist. No.

12910

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>Rockville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Bell Pre Rest Home</b>		d. STREET ADDRESS <b>209 Harrison Street</b>	
3. NAME OF DECEASED (Type or print) <b>Charles A. Whitney</b>		4. DATE OF DEATH <b>November 22, 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 24, 1879</b>
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months <b>2</b> Days <b>28</b>	IF UNDER 24 HRS Hours <b></b> Min <b></b>
10a. USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired) <b>Retired-Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Kansas</b>	11. BIRTHPLACE (State or foreign country) <b>US</b>
12. CITIZEN OF WHAT COUNTRY? <b>US</b>		13. FATHER'S NAME <b>Thomas Whitney</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Jane Strauss</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>INFORMANT</b>		Address <b>Mrs Mary W. Kavanagh-Item# 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1 Myocardial Infarction &amp; cerebral Infarction</b> DUE TO (b) <b>Coronary Thrombosis &amp; cerebral Thrombosis</b> DUE TO (c) <b>Coronary &amp; cerebral arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>1 week</b> <b>Indefinite</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of Prostate</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Feb. 2, 1954</b> to <b>11/22/1961</b> , that I last saw the deceased alive on <b>11/22/1961</b> , and that death occurred at <b>6:40 A.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>Rockville, Md.</b> DATE SIGNED <b>11/22/61</b>			
ACTUAL SIGNATURE <b>Stephen N. Jones</b> M.D.		PHYSICIAN'S NAME (Type) <b>Stephen N. Jones- Rockville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	22b. DATE THEREOF <b>11/22/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>	22d. LOCATION (City, town, or county) (State) <b>Prince George Co., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Maryland</b>		24a. REC'D BY REGISTRAR <b>NOV 27 '61</b>	24b. REGISTRAR'S SIGNATURE <b>Carlton S. French</b>

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4

VS A15 (4)  
15M 9/5B



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

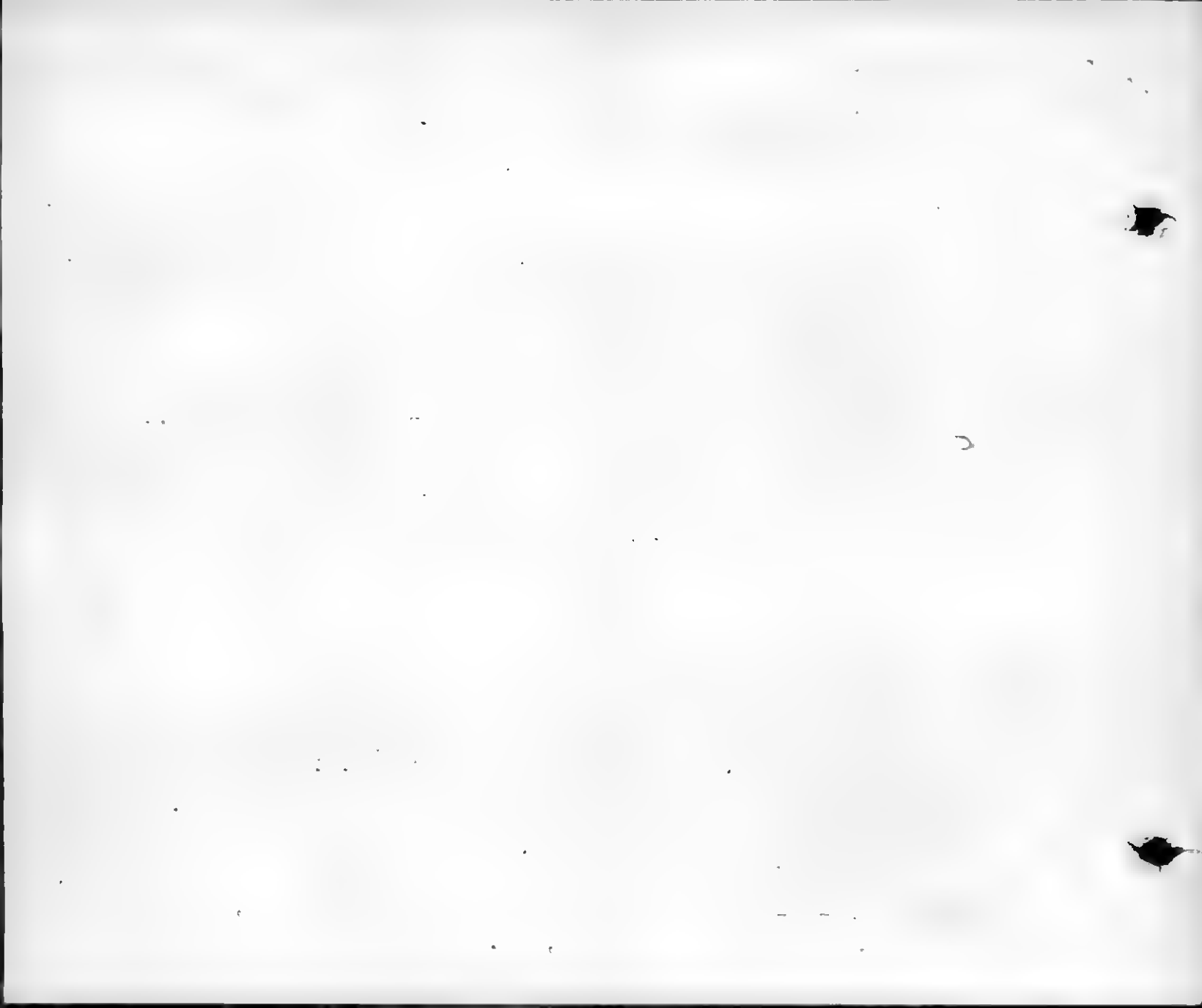
**CERTIFICATE OF DEATH**

12924

12911

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN lb <u>3 1/2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>13118 Lutes Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>William</u> Last <u>Williams</u>		4. DATE OF DEATH Month <u>11</u> Day <u>8</u> Year <u>1961</u>					
5. SEX <u>m.</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-6-03</u>	9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>1</u> Hours <u>1</u> Min.	IF UNDER 24 HRS Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Epps, Louisiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>52612-8933</u>		17. INFORMANT <u>Son - 4715 Arbudas Ave., Rockville, Maryland</u> <u>Dennis E. Williams</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart failure</u> <u>410X</u> DUE TO <u>Rheumatic valvulitis, inactive, mitral</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>and aortic valve</u> (b) <u>years</u> (c) <u>and aortic valve</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-4-61</u> to <u>11-8-61</u> , that (I) (we) last saw the deceased alive on <u>11-8-61</u> , and that death occurred at <u>4:25 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>George H. Gray M.D.</u>				22b. DATE <u>Nov. 8, 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>Geo. H. Gray, M.D.</u>				22d. ADDRESS <u>Suburban Hospital Bethesda Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-10-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		23d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>				25a. REC'D BY REGISTRAR <u>NOV 10 61</u>		25b. REGISTRAR'S SIGNATURE <u>William E. Frank</u>	
ADDRESS <u>Bethesda, Md.</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12912

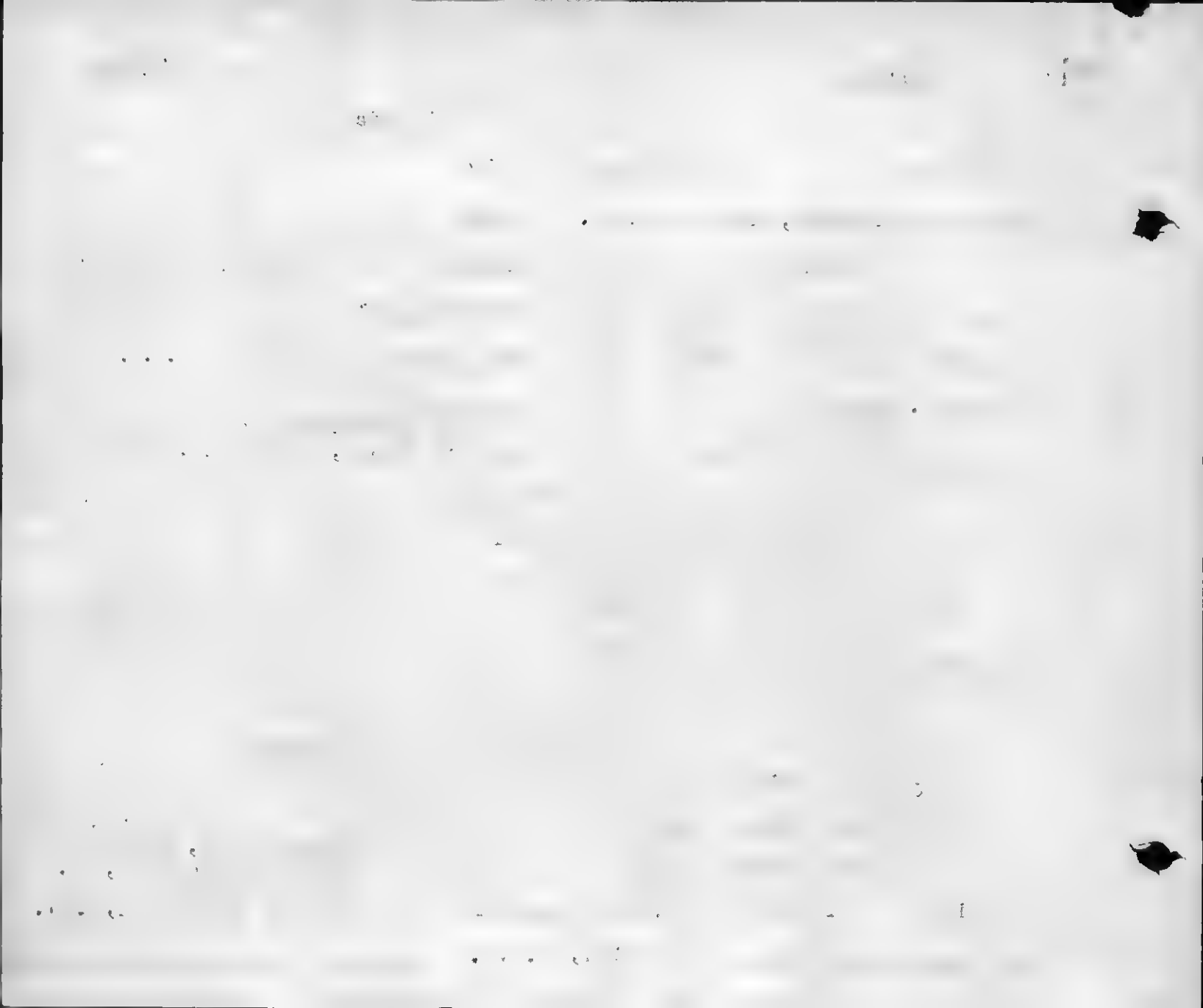
12925

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>169 days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>West Virginia</b>		b. COUNTY	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <b>None</b>		4. DATE OF DEATH <b>November 6 19 61</b>		5. SEX <b>Female</b>	
3. NAME OF DECEASED (Type or print) <b>Zena</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10 September 1901</b>		9. AGE (In years last birthday) <b>60 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>William F. Minter</b>	
14. MOTHER'S MAIDEN NAME <b>Martha Cole</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Records</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinomatosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of the cervix</b> DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (X) (this hospital) attended the deceased from <b>May 21 1961</b> , to <b>November 6, 1961</b> that (X) (we) last saw the deceased alive on <b>November 6, 1961</b> , and that death occurred at <b>1:00 PM</b> , from the causes and on the date stated above.		22a. SIGNATURE <b>Marvin Pomerantz</b>		22b. DATE SIGNED <b>November 6, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Marvin Pomerantz</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/9/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Willis Cemetery</b>	
23d. LOCATION (City, town or county) (State) <b>Grandon Fayette C, W.Va.</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>Frank E. Thomas</b>		24a. ADDRESS <b>Oak Hill, W. Va.</b>		25a. REC'D BY REGISTRAR <b>NOV 16 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Thomas</b>	

VR A15 (4)  
15M 9/60



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1  
FOR STATE  
HEALTH DEPT.

12926

12913

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Takoma Park

c. LENGTH OF STAY IN 1b

5 yrs

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

315 Boyd Ave

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

MD

b. COUNTY

Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Takoma Park

d. STREET ADDRESS

315 Boyd Ave

IS RESIDENCE ON A FARM?  
YES ☐ NO ☒

3. NAME OF DECEASED

(Type or print)

RAYMOND

ALTON-Windsor

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

9-27-1904

9. AGE (In years last birthday)

57 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Painter

10b. KIND OF BUSINESS OR INDUSTRY

Painter

11. BIRTHPLACE (State or foreign country)

Prince George's Co., Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Richard Hamilton Windsor

14. MOTHER'S MAIDEN NAME

Rose Hutchinson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

Mrs. Evelyn Leigear McComas Inc. - Kensington, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)

420.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

INTERVAL BETWEEN ONSET AND DEATH

Sudden

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY  
Hour a.m.  
p.m.

Month, Day, Year

19

20d. INJURY OCCURRED

While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Frank J. Broschert

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

11-14-61

EXAMINER'S NAME (Type)

FRANK J. BROSCHE

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

Nov-17-1961

22c. NAME OF CEMETERY OR CREMATORY

St. Luke's Cemetery

22d. LOCATION (City, town, or country)

Blacksburg, Va.

(State)

23. FUNERAL DIRECTOR

Arthur Walters

24a. ADDRESS

754 Carroll St. N.W.

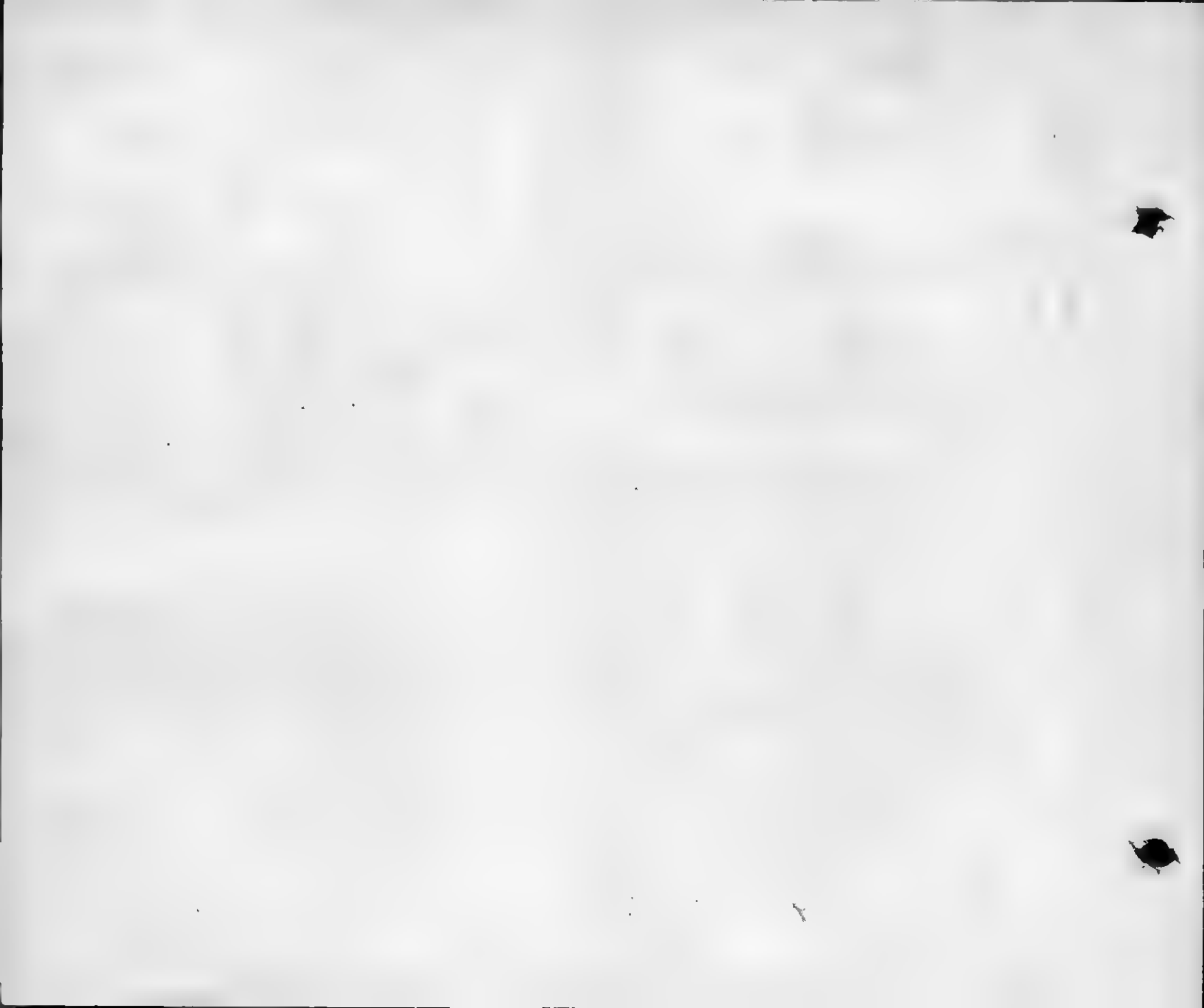
24b. REC'D BY REGISTRAR

DATE NOV 20 '61

24b. REGISTRAR'S SIGNATURE

Arthur S. House

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with item PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12914

12927

1. PLACE OF DEATH  
a. COUNTY **MONTGOMERY CO.**  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **WHEATON**  
c. LENGTH OF STAY IN b. **5+ yrs**  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **12111 VALLEYWOOD DR.**

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)  
a. STATE **MARYLAND**  
b. COUNTY **MONTGOMERY**  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **WHEATON**  
d. STREET ADDRESS **12111 VALLEYWOOD DR.**

3. NAME OF DECEASED (Type or print)  
First **YUVONNE** Middle **PAULINE** Last **WOO**

4. DATE OF DEATH  
Month **NOV.** Day **14** Year **1961**

5. SEX **FEMALE** 6. COLOR OR RACE **CAUCAS.** 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH **August 31, 1922**

9. AGE (In years last birthday) **39** yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Housewife, Secretary** 10b. KIND OF BUSINESS OR INDUSTRY **Office worker** 11. BIRTHPLACE (County & State or foreign country) **Oregon** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **Mr. Marvin Blake** 14. MOTHER'S MAIDEN NAME **Bessie Unknown**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **No** 16. SOCIAL SECURITY NO. **540-28-1981** 17. INFORMANT **Mr. Gayle F. Woo** Address **12111 Valleywood Drive Silver Spring, Maryland**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **410X Probable pulmonary embolus**  
Conditions, if any, which gave rise to immediate cause (b) **Rheumatic Heart Disease mitral stenosis**  
(c), stating the underlying cause last. **4+ yrs.**

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) **NONE**

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

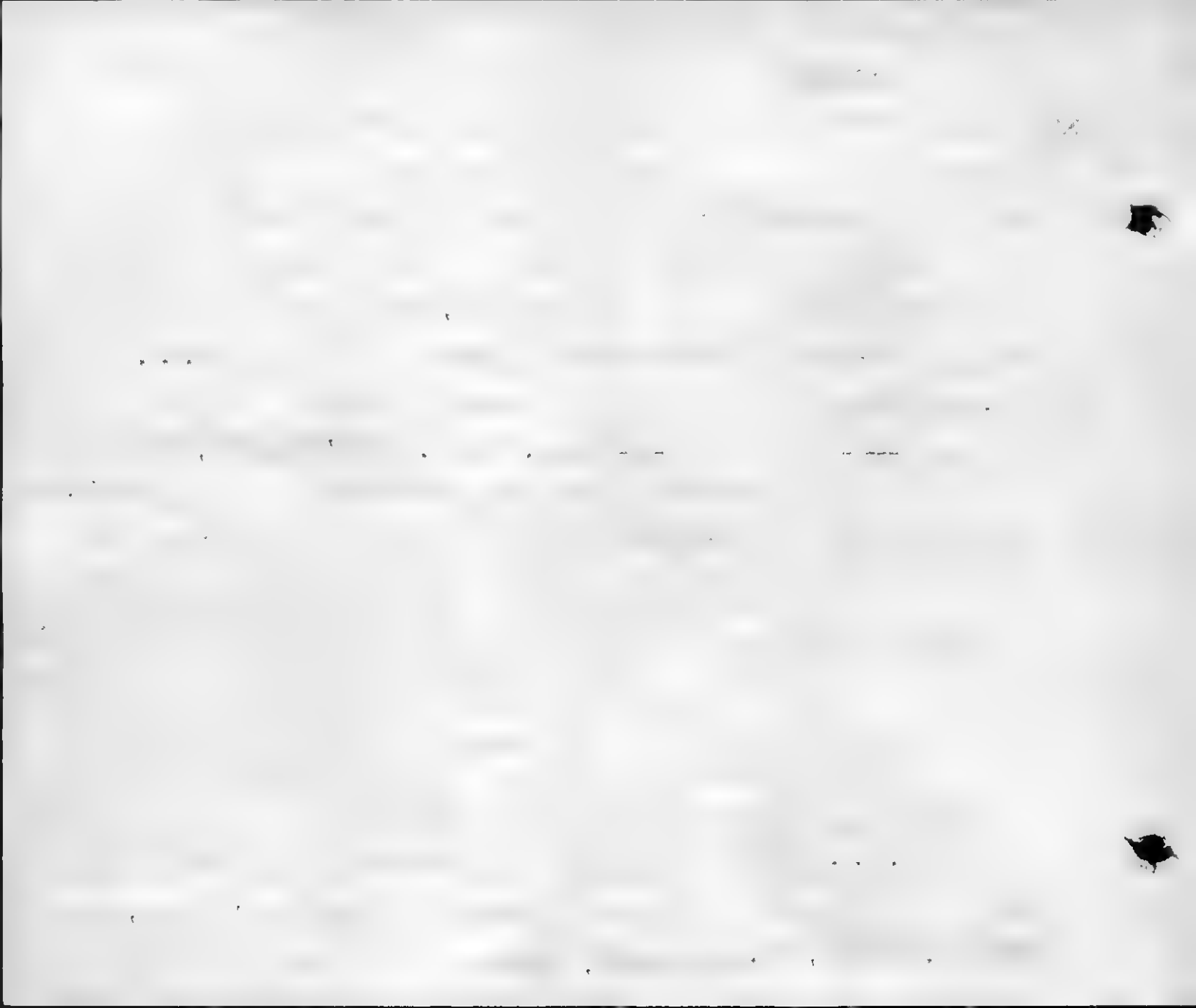
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 **APRIL 1957** 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **15 NOV. 1961** 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from **APRIL 1957** to **MAY 13, 1961**, that (I) (we) last saw the deceased alive on **15 NOV. 1961**, and that death occurred at **7:45 AM** on **NOV. 14, 1961**, from the causes and on the date stated above.

22a. SIGNATURE **G.A. Kelsner, Jr. M.D.** 22b. DATE SIGNED **14 NOV. 1961**  
22c. PHYSICIAN'S NAME (Print) **DR. G.A. KELSNER** 22d. ADDRESS **George WASH. Univ. Hosp. WASH. D.C.**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 23b. DATE THEREOF **11/16/61** 23c. NAME OF CEMETERY OR CREMATORY **Fort Lincoln Cemetery** 23d. LOCATION (City, town or county) (State) **Prince George's County, Maryland**

24. FUNERAL DIRECTOR'S SIGNATURE **Warner E. Pumphrey, Inc.** ADDRESS **434 GEORGIA AVENUE SILVER SPRING, MARYLAND** 25a. REC'D BY REGISTRAR **NOV 16 '61** 25b. REGISTRAR'S SIGNATURE **Arthur S. Kline**



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician.

# MARYLAND STATE DEPARTMENT OF HEALTH

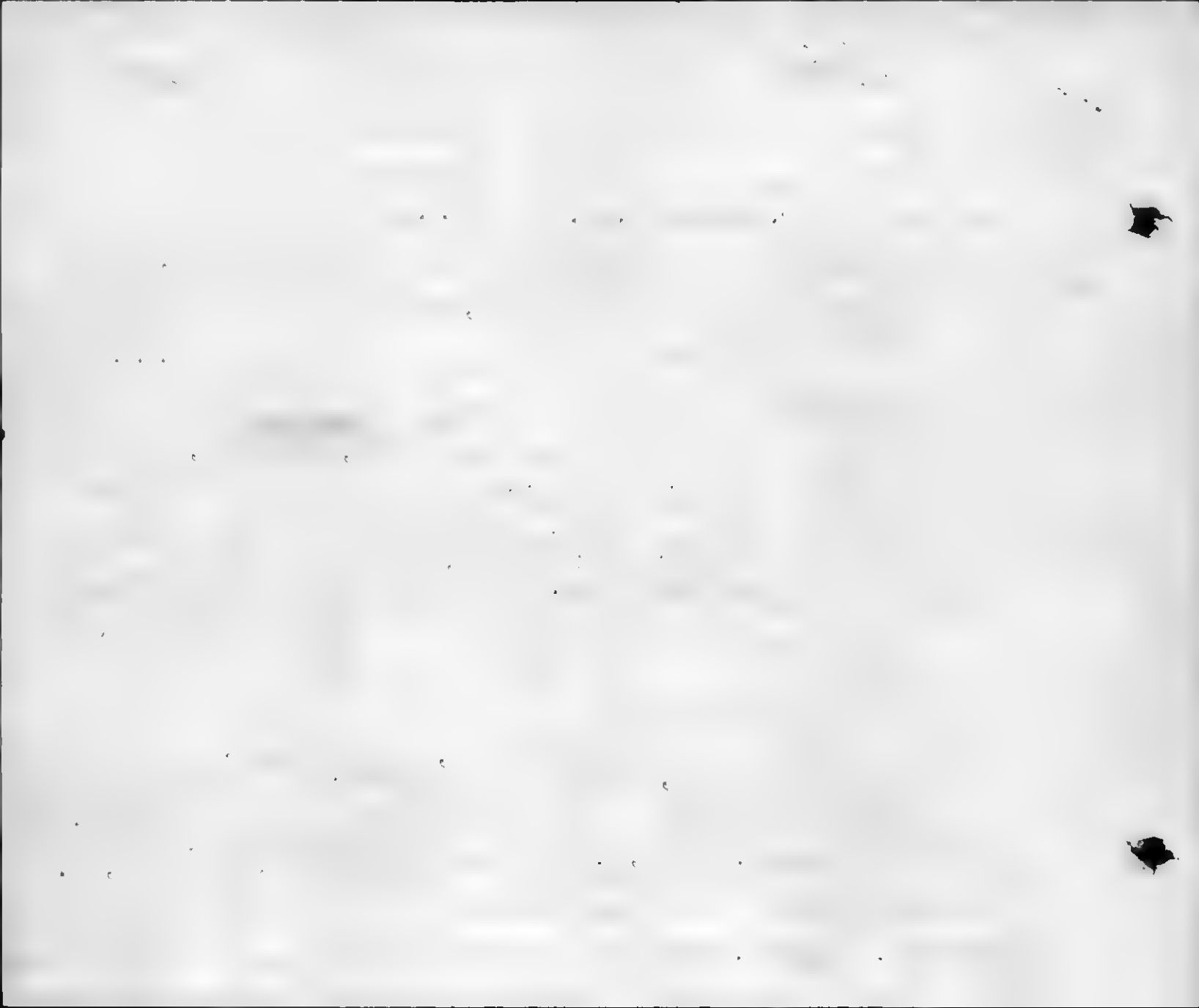
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12928

12915

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>46 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Florida</u> b. COUNTY <u>Deerfield Beach</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>804 S.E. 14th Court</u> d. STREET ADDRESS <u>43 x 3</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Ruth Alice Wood</u>		<b>4. DATE OF DEATH</b> <u>November 19, 1961</u>	
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>	
<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>July 5, 1904</u>	
<b>9. AGE</b> (In years last birthday) <u>57 yrs.</u>		<b>10. AGE</b> (In years last birthday) <u>57 yrs.</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>New Jersey</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Fred G. Vansyckle</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>	
<b>17. INFORMATION</b> <u>The Medical Records</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO <u>211X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoid Heart Disease</u> (c) <u>Metastatic Carcinoid tumor, primary in ileum.</u>	
<b>19. INTERVAL BETWEEN ONSET AND DEATH</b> <u>1 year</u>		<b>20. INTERVAL BETWEEN ONSET AND DEATH</b> <u>1 year</u>	
<b>21. INTERVAL BETWEEN ONSET AND DEATH</b> <u>3 1/2 years</u>		<b>22. INTERVAL BETWEEN ONSET AND DEATH</b> <u>3 1/2 years</u>	
<b>23. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</b>		<b>24. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</b>	
<b>25a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>		<b>25b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)	
<b>26a. TIME OF INJURY</b> Month, Day, Year <u>19</u>		<b>26b. INJURY OCCURRED</b> <u>While at work</u> <input type="checkbox"/> <u>Not While at work</u> <input type="checkbox"/>	
<b>26c. PLACE OF INJURY</b> (Home, farm, factory, street, office b.d.g., etc.)		<b>26d. (City or town)</b> <u>October 4, 1961</u>	
<b>26e. (County)</b> <u>November 19, 1961</u>		<b>26f. (State)</b> <u>that (we) last saw the deceased alive on November 19, 1961 and that death occurred at 1:10 PM from the causes and on the date stated above.</u>	
<b>27a. SIGNATURE</b> <u>Frederick H. Welland</u>		<b>27b. DATE SIGNED</b> <u>November 20, 1961</u>	
<b>27c. PHYSICIAN'S NAME</b> (Type) <u>Frederick H. Welland, M.D.</u>		<b>27d. ADDRESS</b> <u>The Clinical Center, National Institutes Of Health, Bethesda 14, Md.</u>	
<b>28a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Cremation</u>		<b>28b. DATE THEREOF</b> <u>11/22/61</u>	
<b>28c. NAME OF CEMETERY OR CREMATORY</b> <u>Rosedale Crematory</u>		<b>28d. LOCATION</b> (City, town or county) <u>Orange, New Jersey</u>	
<b>29. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Pumphrey, Bethesda, Maryland</u>		<b>29a. REC'D BY REGISTRAR</b> <u>NOV 24 '61</u>	
<b>29b. REGISTRAR'S SIGNATURE</b> <u>C. S. Thomas</u>		<b>29c. REGISTRAR'S SIGNATURE</b> <u>C. S. Thomas</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

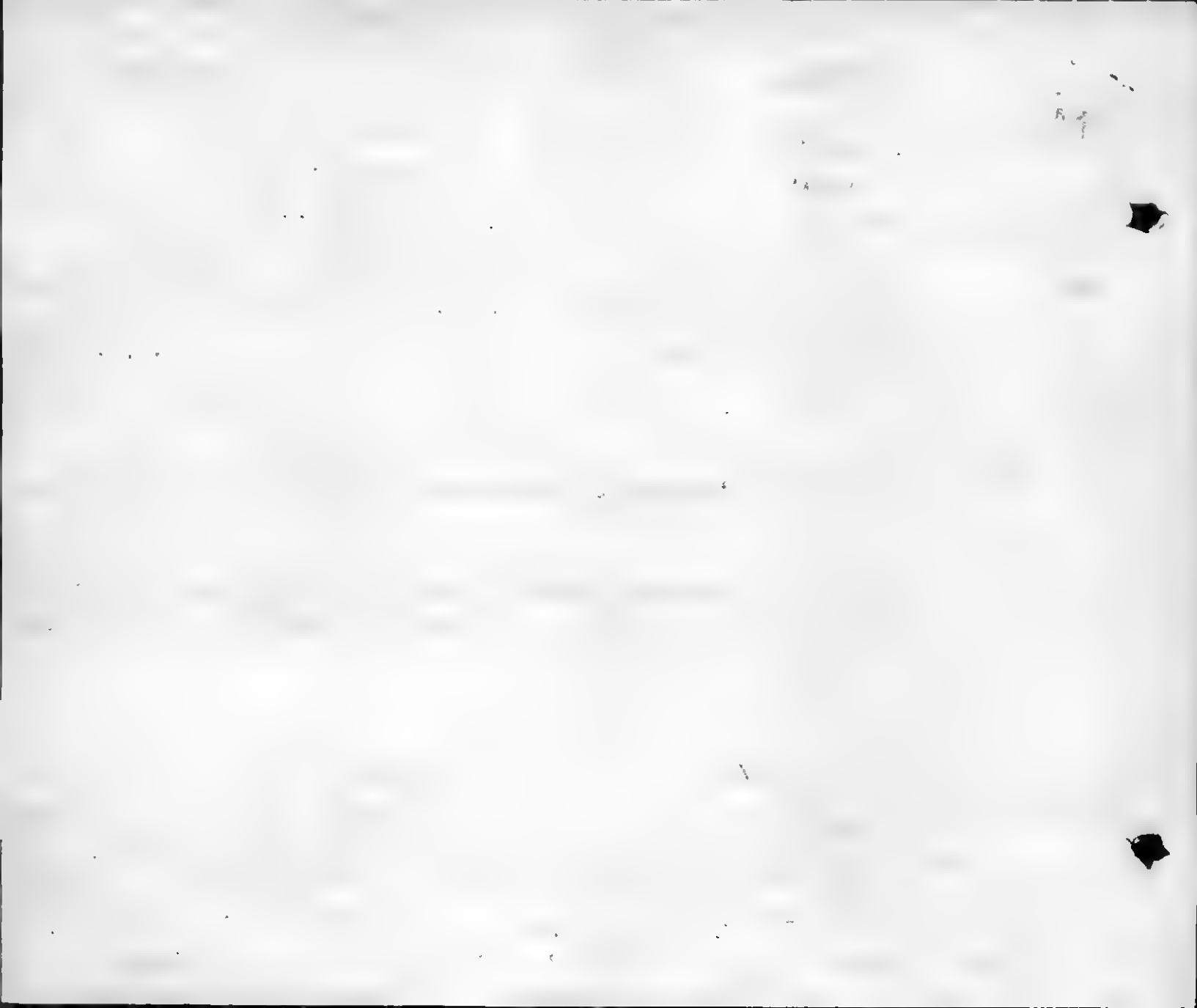
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12929

1291C

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery County</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington, Md.</u> c. LENGTH OF STAY IN TB <u>4 mos.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>LeDeau Gardens</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town, <u>Bethesda 14, Maryland</u> X d. STREET ADDRESS <u>8605 McKinley Ct.,</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Etha</u> Middle <u>K.</u> Last <u>Young</u> 4. DATE OF DEATH Month <u>Nov.</u> Day <u>2</u> Year <u>1961</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Feb. 14, 1886</u> 9. AGE (In years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>In home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Benjamin Kountz</u> 14. MOTHER'S MAIDEN NAME <u>Emma Henneberger</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service) 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Martha McLain</u> Address <u>as above</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) <u>Broncho pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cerebral Arteriosclerosis - Senile</u> (c) <u>Arteriosclerotic H.D. - Diabetes Mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u>3-4 yrs.</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>Oct 10-1, 1961</u> to <u>10-2, 1961</u> , that (I) (we) last saw the deceased alive on <u>10-1, 1961</u> , and that death occurred at <u>1255AM</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>William Kurstin</u> 22c. PHYSICIAN'S NAME (Type) <u>William Kurstin</u> 22b. DATE SIGNED <u>11-2-61</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>915 19th St. NW - D.C.</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>11-6-61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Hagerstown, Maryland</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Art. G. Humphrey</u> 25a. REC'D BY REGISTRAR <u>NOV 6 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3 & 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3 & 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3 & 4 may be retained by the hospital or attending physician.

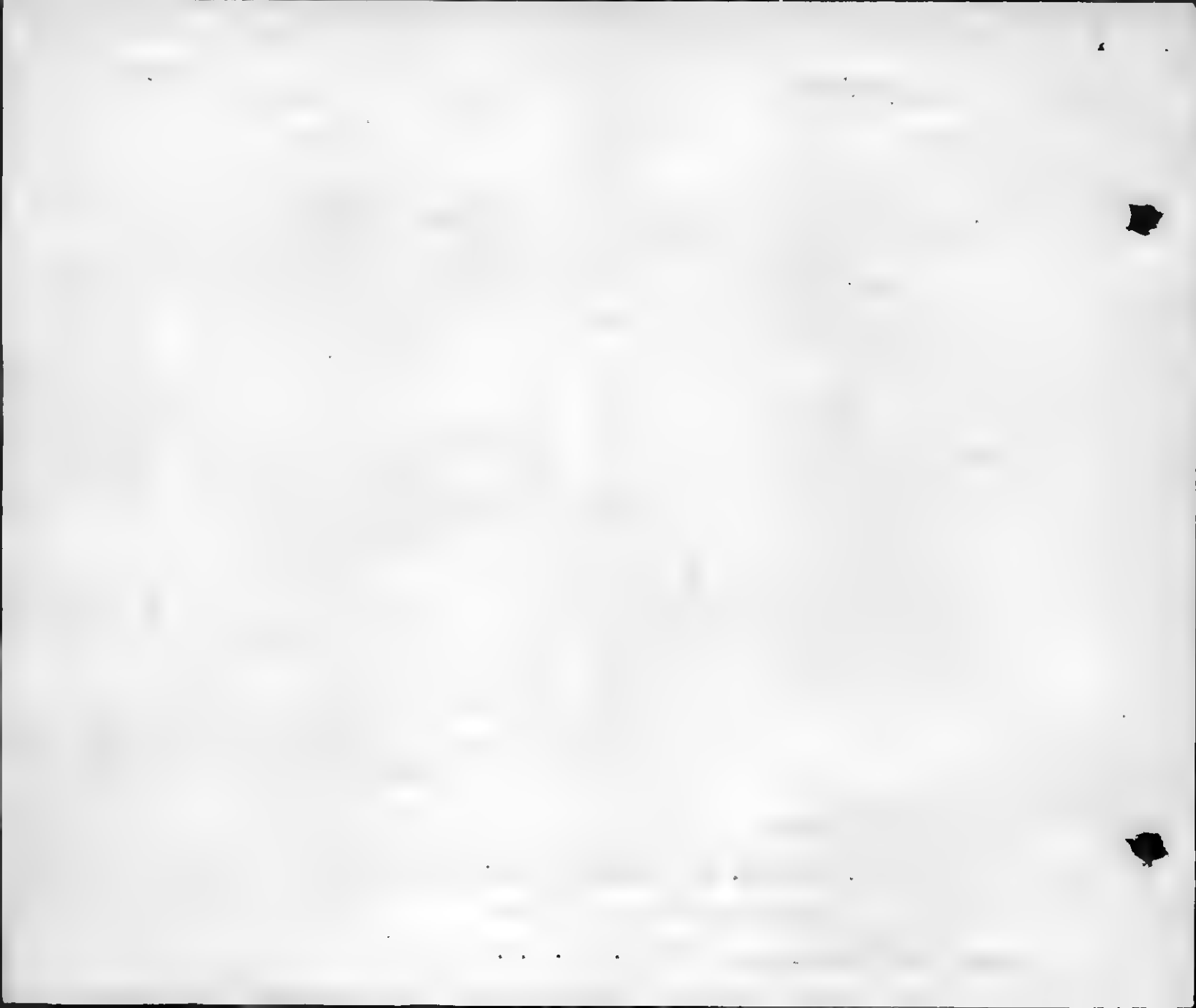
# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12917

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN TB <b>3 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>4412 39th. Street NW</b>	
3. NAME OF DECEASED (Type or print) <b>Mary Catherine Youngkin</b>		4. DATE OF DEATH Month <b>November</b> Day <b>9</b> Year <b>1961</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 18, 1886</b>	
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>15</b>	
11. IF UNDER 24 HRS. Hours <b>15</b> Min. <b>00</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edward A. Peckham</b>		14. MOTHER'S MAIDEN NAME <b>Ellen Dempsey</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>HUSBAND: Rodney J Youngkin, Same as #12</b>	
17. INFORMANT <b>HUSBAND: Rodney J Youngkin, Same as #12</b>		Address <b>Same as #12</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Encephalopathy</b> DUE TO <b>acute and chronic cerebral vascular occlusion</b> (b) <b>6 yrs</b> DUE TO <b>Atherosclerosis</b> (c) <b>6-10 yrs+</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <b>November 7, 1961</b> , to <b>November 9, 1961</b> , that (X) (we) last saw the deceased alive on <b>November 9, 1961</b> , and that death occurred at <b>12:45 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert E. DeForest</b>		22b. DATE SIGNED <b>November 9, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>ROBERT E. DEFOREST, LT MC USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>13 Nov 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Thoms</b>		25a. REC'D BY REGISTRAR <b>NOV 15 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoms</b>		25c. ADDRESS <b>5010 Wis. Ave. N.W. WDC</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12931

12918

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8103 Kentbury Drive</b>		d. STREET ADDRESS <b>8103 Kentbury Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>KENNA</b> Middle <b>D.</b> Last <b>Z OGRAFOVA</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>13,</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/1/1889</b>
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months <b>9</b> Days <b>12</b>	11. IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Yugoslavia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA-Nat.</b>	
13. FATHER'S NAME <b>Gerasimo Serafim</b>		14. MOTHER'S MAIDEN NAME <b>(Unknown) Paraskeva</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Sylvia Brammer-daughter-same 2d</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pectoris Angina</b> 4-20-61 DUE TO (b) <b>Arterio-sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Heart</b> INTERVAL BETWEEN ONSET AND DEATH <b>5:30</b> <b>6:00</b> <b>half hour</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March, 1952</b> to <b>Nov 10, 1961</b> , that (I) (we) last saw the deceased alive on <b>Nov 10, 1961</b> , and that death occurred at <b>6:00</b> M. from the causes and on the date stated above.			
22a. SIGNATURE <b>Antoinette F. Popovici</b>		22b. DATE SIGNED <b>Nov 14-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>ANTOINETTE F. POPOVICI</b>		22d. ADDRESS <b>Room 319</b> <b>1835 Eye Street, N.W., Washington, D. C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/15/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Prince Geo. Co., Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>NOV 16 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY in 1b <u>6 1/2 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hosp.</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Rockville</u> d. STREET ADDRESS <u>5704 Dimes Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <u>Infant Male HAGINS</u> 5. SEX <u>Male</u> 6. COLOR OR RACE <u>Colored</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>Nov. 24 1961</u> 9. AGE (In years last birthday) <u>6 1/2</u> yrs. IF UNDER 1 YEAR: Months <u>6</u> Days <u>13</u> IF UNDER 24 HRS.: Hours <u>13</u> Min. <u>01</u>						<b>4. DATE OF DEATH</b> <u>Nov 30 19 61</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> 11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
<b>13. FATHER'S NAME</b> <u>IRA HAGINS</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Beatrice Turner</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>—</u> (If yes give war or dates of service) <u>—</u>						<b>16. SOCIAL SECURITY NO.</b> <u>—</u> <b>17. INFORMANT</b> (Mother) <u>Same as above</u>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immature</u> 761.5 DUE TO <u>Perinatal Asphyxia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>—</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>—</u>											
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>											
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>11-29-61</u> Hour a.m. <u>—</u> p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>—</u>			
<b>20f. (City or town)</b> <u>—</u> <b>(County)</b> <u>—</u> <b>(State)</b> <u>—</u>				<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>11-29</u> <b>to</b> <u>11-30</u> <b>19</b> <u>61</u> <b>that (I) (we) last saw the deceased alive on</b> <u>11-30</u> <b>and that death occurred at</b> <u>4:30 P.M.</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>A. Jorgensen</u> M.D.						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>			<b>22b. DATE SIGNED</b> <u>Nov 30, 1961</u>		
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>A. Jorgensen</u>						<b>22d. ADDRESS</b> <u>—</u>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>CREMATION</u>				<b>23b. DATE THEREOF</b> <u>12-2-61</u>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>SUBURBAN HOSPITAL</u>			
<b>23d. LOCATION (City, town or county)</b> <u>BETHESDA - MARYLAND</u>				<b>23e. REC'D BY REGISTRAR</b> <u>—</u>				<b>23f. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kline</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>AMELIA C. CARTER, ADMIN. - SUBURBAN HOSPITAL</u> <b>ADDRESS</b> <u>BETHESDA, MD.</u> <b>DATE</b> <u>DEC 11 '61</u>											

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